California MEDICINE

AUGUST 1953

The 1952 Outbreak of Encephalitis in California *(A Symposium)*

OFFICIAL JOURNAL
OF THE CALIFORNIA MEDICAL ASSOCIATION

UME 79 NUMBER 2

California MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

Volume 79 • AUGUST 1953 • No. 2

The 1952 Outbreak of Encephalitis in California

Differential Diagnosis

ROBERT H. KOKERNOT, M.D., D.V.M., M.P.H., HENRY R. SHINEFIELD, M.D., and W. ALLEN LONGSHORE, JR., M.D., M.P.H., Berkeley

• Clinical data adequate for analysis were available in 386 laboratory-confirmed cases of arthropod-borne encephalitis — 38 St. Louis and 348 western equine. Consistently observed symptoms varied with the age of the patient. Symptoms that occurred in a high proportion of patients in each age group were:

Less than one year of age: Fever and convulsions. (None had the St. Louis disease.)

One through four years: Fever, headache, vomiting, drowsiness, irritability, restlessness, nuchal rigidity, tremor, and sometimes convulsions.

Five through fourteen years: Headache, fever, and drowsiness. Sometimes the disease progressed no further, but if it did, nausea, vomiting, muscular pain, photophobia and limitation of neck and back flexion often were noted; and sometimes convulsions and intention tremors.

Fifteen years and older: Drowsiness, lethargy, malaise, fever, stiffness at the back of the neck and, almost always, severe intractable occipital headache associated with nausea, disturbance of vision, photophobia and vertigo.

The extreme difficulty of differential diagnosis on the basis of clinical observation was indicated by the wide range of diagnoses made in these cases before the invading organism was identified by laboratory studies.

THE PURPOSE OF THIS PAPER is to present the clinical characteristics of the arthropod-borne encephalitides as observed during the 1952 outbreak in the Central Valley of California. The objective is to set forth the salient clinical features of the so-called "typical case" and to point out the features less commonly associated with this disease. The problems in the differential diagnosis have been commented on by others.[2, 5, 9, 10, 18, 19]

The analysis of clinical material is based on 792 reported cases of acute infectious encephalitis for the period June to October, 1952. Particular attention is given to 386 laboratory confirmed cases of arthropod-borne encephalitis on which adequate clinical information was available for analysis. Of the 386 cases in which the etiologic factor was determined and there were adequate clinical data, 348 were caused by western equine virus and 38 by St. Louis virus.

The serological tests and viral isolations were performed by the Viral and Ricksettsial Disease Laboratory of the California State Department of Public Health. The etiologic factor was considered established when significant rises in titers of either complement-fixing or neutralizing antibody or both,

From the Bureau of Acute Communicable Diseases, California State Department of Public Health, Berkeley. (Dr. Shinefield participated by special assignment from the Epidemiology Section, Communicable Disease Center, Public Health Service, U. S. Department of Health, Education and Welfare, Atlanta, Georgia.)

Part of the Symposium on Encephalitis presented by the Section on Public Health at the 82nd Annual Session of the California Medical Association, Los Angeles, May 24-28, 1953.

LABORATORY CONFIRMED CASES OF WESTERN EQUINE AND ST. LOUIS ENCEPHALITIS, PERCENT IN EACH AGE GROUP MANIFESTING SELECTED CLINICAL SIGNS AND SYMPTOMS CALIFORNIA, 1952

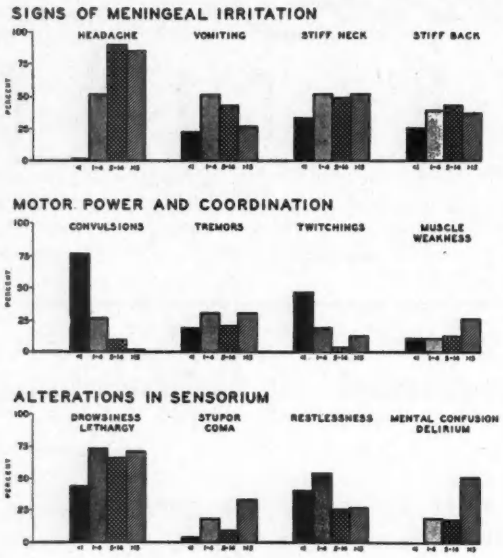


CHART 1

were demonstrable, or when in fatal cases the virus was recovered from the brain.[16]

The available data were compiled from observations by epidemiological field teams, members of hospital staffs and practicing physicians. Because of the number and variety of observers, there were difficulties in obtaining complete, consistent and comparable clinical data on this group of proven cases.

Detailed epidemiological data are given in a paper by Hollister and co-workers.[14] However, it should be pointed out that there was wide variation in the ages of patients and the ability to elicit subjective and objective symptomatologic information varied with age groups. It was felt, therefore, that a discussion of the clinical features should be considered by age groups. The four divisions that have been made are as follows: Infants less than 1 year of age, infants and children 1 through 4, children 5 through 14, and patients 15 years of age and over. Clinically the western equine and St. Louis types have much in common[8, 10, 17] and, therefore, they will be discussed together.

CLINICAL FINDINGS

All cases in infants less than one year of age were caused by the western equine virus. In this age group the only consistently noted symptoms were sudden onset of fever accompanied by convulsions.

TABLE 1.—*Signs and symptoms of arthropod-borne encephalitis* by age group*

	Under 1 year	1-4	5-14	15 and over
Total cases	94†	52†	53†	187†
Signs and Symptoms	Per cent			
Pyrexia	92	81	94	91
Less than 100° F.	1	4	6	4
100-101.9	5	6	9	7
102-103.9	38	38	53	39
104 and over	48	33	26	41
Not stated	8	19	6	9
Signs of meningeal irritation				
Headache	1	52	91	87
Nausea	1	22	30	30
Vomiting	22	52	43	27
Stiff neck	33	52	49	52
Stiff back	25	39	43	36
Alterations in sensorium				
Drowsiness	36	67	59	66
Lethargy	26	54	42	51
Malaise	5	31	34	40
Stupor	2	14	6	28
Coma	2	8	4	13
Restlessness	40	54	25	26
Mental confusion	....	17	15	44
Delirium	....	8	6	14
Motor power and coordination				
Convulsions	77	27	9	1
Tremors	19	29	20	29
Twitchings	47	19	3	12
Muscle weakness	10	10	11	26
Dysarthria	....	8	....	7
Ocular signs or symptoms				
Strabismus	1	4	4	6
Diplopia	....	4	4	8
Blurred vision	....	....	2	5
Photophobia	....	14	8	12
Conjunctivitis	1	2	2	6

* Proved cases of western equine and St. Louis encephalitis.
† Number of cases in each group.

(There was no history of antecedent complications at delivery or in the neonatal period.) It was observed that while the convulsions were frequently generalized, they often were focal, involving one or both of the upper or lower extremities. Typically, the fever ranged between 102° and 104° F., rectally during the course of illness, but frequently the maximum was over 104° F. The temperature remained high despite chemotherapy. Findings related to tenseness of the fontanel, abnormality of reflexes, and degrees of rigidity of extremities were difficult to evaluate and could not be relied upon to aid in the diagnosis. The consistent observations in this age group were fever (in 92 per cent of cases) and convulsions (in 77 per cent) as shown in Table 1 and graphically in Chart I.

In the age group 1 through 4 years, the complaints of fever and convulsions were mentioned but were not typical characteristics. The history obtained on admittance to hospital usually indicated fever, headache, vomiting, drowsiness, irritability and restlessness of one to three days' duration. The

most consistent positive physical findings in these cases were fever, nuchal rigidity, and tremor (Table 1). Muscular weakness was observed in 10 per cent of the cases. In one case of western equine encephalitis, brain stem and cord involvement was indicated by absence of the gag reflex, facial paralysis and intercostal paralysis. Tracheotomy was necessary in that case. Within a period of nine months the child progressively recovered with no evident residual muscle weakness.

In the age group 5 through 14 years, subjective symptoms were more easily elicited (Table 1). Headache, fever and drowsiness often existed two to three days before admittance to hospital. In many instances the illness progressed no further and a definite diagnosis was made only because specimens of blood were examined. In cases in which the disease progressed, the previously mentioned subjective symptoms became more intense and were often associated with nausea, vomiting, muscular pain, photophobia and, less frequently, convulsions. These children were acutely ill, febrile and lethargic. Often there was limitation of flexion in the neck and back. Intention tremors were not infrequent and in one case the tremor was pronounced enough to suggest an initial diagnosis of Sydenham's chorea. Muscular weakness was observed in 11 per cent of patients and it persisted a week or longer. Tracheotomy was performed on one patient with western equine encephalitis in this age group because of bulbar and cervical cord involvement.

In patients 15 years of age or older, the initial complaints were "grippe-like," characterized by generalized malaise, drowsiness, lethargy, fever, tight or stiff sensation in the back of the neck, and intense headache of two to four days' duration as noted in Table 1. Headache was almost a universal symptom (86 per cent) and was commonly so severe as to dominate all subjective symptoms. The pronounced incapacitation caused by headache was frequently the sole reason adults sought medical attention. Typically, the headache was localized in the occipital region, was throbbing in character, and usually was not relieved by analgesic drugs, including narcotics. Movement, upright position or coughing often caused accentuation in the intensity of the pain. Phenomena associated with the headache included nausea, vomiting, blurring of vision, diplopia, strabismus, vertigo and photophobia.

Shortly after onset, the typical adult patient became mildly disoriented and drowsy and had signs of meningeal irritation. Tremors of intention type were not uncommon and were often rather coarse. Tremors involving facial musculature, including the lips, were rather frequently noted. In many cases the disease was mild and the patient was apparently well within a few days. Complete stupor developed in 28 per cent of the more severe cases, for the most part in patients in the higher brackets of the age group. Thirteen per cent of patients in this age group became comatose and were incontinent for three or four days or longer and finally recovered from this critical state. These observations are similar to those made by Adamson[1] in a study of cases in the Manitoba outbreak in 1941. Adamson emphasized that this is the only brain condition in which unconsciousness may persist for so long without being followed by death or gross disability.

There were three patients in this age group, two with western equine and one with St. Louis encephalitis, who had definite indications for tracheotomy. All three recovered, but the patient with St. Louis encephalitis had residual flaccid paralysis of the lower extremities of a known duration of eight months. Tracheotomy was also done in two cases in which encephalitis was diagnosed clinically but the results of laboratory tests were inconclusive.

LABORATORY DATA

Routine laboratory examination of urine and blood were of little diagnostic assistance in this study. The most common urinary finding was transient albuminuria. In examination of the blood, neither leukopenia nor leukocytosis was consistently observed. Usually slight, transient leukocytosis was noted. Examination of the cerebrospinal fluid, while important as a diagnostic aid in central nervous system disease, showed wide variation in the total number of cells as well as in the differential count. Usually the total number of cells ranged from 50 to 200 per cubic millimeter with polymorphonuclear leukocytes predominating early. Lymphocytes were more numerous later in the course of the disease. In infants the cerebrospinal fluid showed a greater degree of pleocytosis than was observed in older patients. Fifty-one per cent of infants less than one year of age had spinal fluid cell content of more than 300 per cubic millimeter and 31 per cent had more than 500 per cubic millimeter. Sugar and chloride values in all age groups were normal and the protein content was either normal or slightly to moderately elevated.

The most important aspect of the virus laboratory examination is the demonstration of a rise in titer of either complement fixing or neutralizing antibodies in two or more serum samples taken in the acute and convalescent phase of the disease. (This is discussed in detail in a paper by Lennette and coworkers.[16]) In fatal cases, specific etiological diagnosis may be made by isolation of the virus from central nervous system tissue.

DIFFERENTIAL DIAGNOSIS

The experience with encephalitis in California in 1952 reemphasized the difficulties involved in establishing on clinical grounds a diagnosis of the arthropod-borne virus encephalitides. Table 2 shows the wide range in the initial diagnoses considered by the attending physicians in cases in which laboratory tests ultimately proved either western equine or St. Louis encephalitis. The outstanding clues that should at once arouse suspicion of either the western equine or the St. Louis virus as the etiologic agent are the dramatic seasonal incidence and the rather sharply defined area of endemicity of the two diseases.[14]

Clinical laboratory aids in diagnosis are essential to rule out other conditions in which there may be primary or secondary encephalitic components. Cerebrospinal fluid examinations, including cell counts, smears, cultures, animal inoculations, chlorides and protein determinations, as well as serologic tests are important in the exclusion of acute bacterial meningitis, acute syphilitic meningitis, tuberculous meningitis and coccidioidal infection of the central nervous system. In this regard, it is important to emphasize that in a large proportion of the cases in infants the content of cells in the spinal fluid noted in association with either of the two arthropod-borne encephalitides was similar to the cell content associated with bacterial infection. Thus, cell content of 500 or more per cubic millimeter does not rule out virus encephalitis.

A complete case history supplemented by physical and laboratory examinations will aid in ruling out such conditions as postinfectious encephalitis[13, 23] following mumps, measles and chickenpox, postvaccinal encephalitis,[6, 26] brain and cord tumors and abscesses, metabolic and general vascular disturbances, toxic encephalopathic conditions and miscellaneous conditions such as subacute bacterial endocarditis, ricksettsial involvement of the central nervous system[12] and Guillain-Barre syndrome.

Sometimes the arthropod-borne encephalitides can be differentiated from polioencephalomyelitis, but usually there is much difficulty in distinguishing between them.[3, 4, 11] Until a simple test for identification of the virus of poliomyelitis becomes available, its role as a causative factor in the many cases in which the infecting organism is not identifiable by present means, will remain obscure.[22] Both are likely to occur in the Central Valley of California during the summer and early fall months. In both conditions, onset with headache and fever is common.[25] However, sudden onset, occasionally fulminating, with high temperature usually indicates arthropod-borne encephalitis as the more likely.

Although development of paralysis or bulbar symptoms soon after onset is presumptive of poliomyelitis, it is important to keep in mind that these complications occurred also in laboratory-confirmed cases of encephalitis: Tracheotomy was necessary in five cases of proven encephalitis, four western equine and one St. Louis, in 1952.

TABLE 2.—*Initial diagnosis of diseases ultimately proven by laboratory test to be either western equine or St. Louis encephalitis*

Polioencephalomyelitis	Brain trauma
Bacterial meningitis	Brain abscess
Tuberculous meningitis	Cerebrovascular accident
Mumps encephalitis	Intracranial hemorrhage
Coccidioidal infection	Intracranial neoplasm
Lymphocytic choriomeningitis	Convulsive disorder
Central nervous system syphilis	Cardiac failure
Coxsackie encephalitis	Subacute bacterial endocarditis
Pneumonia	Sydenham's chorea
Otitis media	Diabetic coma

The variegated clinical manifestations in this group of diseases arises from the fact that any of them may affect any portion of the encephalon and myelon. Quong[20] in a study of 18 deaths in proven cases that occurred in a severe epidemic of western equine encephalitis in Manitoba in 1941, described in addition to brain lesions diffuse cord lesions which extended to both anterior and posterior horns.

Sulkin,[24] reporting on histopathologic observations in a fatal case in which the western equine virus was isolated, stated: "The inflammatory reaction was most apparent in the spinal cord, but involved the medulla, pons and midbrain to a striking degree. No inflammatory reaction was evident in the cerebrum, corpus striatum or cerebellum."

In the 1952 outbreak, Huntington,[15] pathologist at Kern General Hospital, observed lesions in the segments of the upper cervical cord in a number of confirmed cases.

In light of these pathologic changes, it is easier to understand the bulbar and lower motor neuron signs that are occasionally observed in the arthropod-borne encephalitides. These may result in flaccid paralysis of single extremities with absence of deep tendon reflexes, signs of involvement of cranial nerves or respiratory distress which may necessitate tracheotomy or the use of a respirator. In one case, there was a unilateral sensory loss over the area of distribution of the ophthalmic branch of the fifth cranial nerve.

DISCUSSION

As has been pointed out by a number of investigators,[7, 8, 17] it is impossible to differentiate western equine from St. Louis encephalitis clinically. Malodorous perspiration in cases of western equine encephalitis noted by Hammon[8] in his report on encephalitis in Yakima was of no differential diagnostic significance in the authors' experience. Final

diagnosis rests with the demonstration of a rise in titer of specific antibodies in the serum of the patient. Reeves[21] reported that 20 per cent of a "normal population" in an endemic area had neutralizing antibodies to St. Louis virus and 10 per cent had evidence of contact with western equine virus. Therefore, a single specimen of blood with neutralizing antibody has little diagnostic significance. Conversely, negative result of a test of a single specimen taken in the acute phase does not rule out the disease. Antibodies may appear at varying time intervals after the beginning of the illness with either western equine or St. Louis encephalitis. At least two specimens of serum are, therefore, necessary in order to show that antibodies have appeared or increased in titer during the course of the illness. The first specimen should be taken as early in the course of the disease as possible; the second, ten days or more after the first. Sometimes it is necessary to obtain a third, fourth or even fifth specimen to establish a diagnosis. Of note is the fact that in 34 of the cases in the 1952 epidemic there was no antibody rise until approximately 35 or more days after onset of illness.

It should be stressed that in addition to the 386 laboratory confirmed cases, there were 198 cases in the category of encephalitis, "etiologic agent not known." No antibody rise could be demonstrated to viruses of western equine or St. Louis encephalitis or mumps in a series of blood specimens. Results of tests, done later, of these negative specimens for antibodies of eastern equine, Japanese B, lymphocytic choriomeningitis and California viruses were also negative. Analysis of clinical signs and symptoms reported in this group shows them to be strikingly comparable to those observed in the "laboratory confirmed" group. This relationship, suggesting that as yet undiscovered etiologic agents may be responsible for the syndrome of encephalitis, has previously been described.[9, 17] Clarification of this problem apparently must await further epidemiologic studies, the development of better serologic tools to assist in establishing a specific etiologic diagnosis and, possibly, on the isolation of new etiologic agents.

In the event of death, postmortem examination is highly desirable, both for histopathological studies and for isolation of etiological agents from the brain and central nervous system tissue. On the basis of observation in the laboratory confirmed cases, it is well to reemphasize the value of the histopathological studies—not only of the brain and upper cervical cord that can be obtained through the foramen magna, but also of the entire cord.

2180 Milvia Street.

REFERENCES

1. Adamson, J. D., and Dubo, Sara: Clinical findings in encephalitis (western equine), Canad. Pub. Health J., 33: 288, June 1942.

2. Black, W. C., Agsher, W. K., and McDonald, J. G.: Epidemic encephalitis in Colorado, Rocky Mtn. Med. J., 42: 354, May 1945.

3. Buss, W. C., and Eaton, J.: Encephalitis in Kern County, California, 1941-1950, Calif. Med., 76:350, May 1952.

4. Clark, S. B., and Finley, K. H.: Some clinical aspects of the human arthropod-borne virus encephalitides in California as a diagnostic aid to physicians. Unpublished data.

5. Dingle, J. H.: The encephalitides of virus etiology, N.E.J.M., 225:1014, 1941.

6. Editorial: "Encephalitis Following Vaccination Against Pertussis," Ann. Int. Med., 32:343, Feb. 1950.

7. Finley, K. H.: Virus encephalomyelitides, The Med. Clinics of N. A., 37:373, March 1953.

8. Hammon, W. McD.: Encephalitis in the Yakima valley. Mixed St. Louis and western equine types, J.A.M.A., 117:161, July 1941.

9. Hammon, W. McD.: The encephalitides of virus origin with special reference to those of North America, The Med. Clinics of N. A., Vol. IV, No. 2, 1945.

10. Hammon, W. McD.: The epidemic encephalitides of North America, The Med. Clinics of N. A., May 1943.

11. Hammon, W. McD., and Reeves, W. C.: Interepidemic studies on arthropod-borne virus encephalitides and poliomyelitis in Kern County, California and the Yakima valley, Washington, 1944, Amer. J. Hyg., 46:326, Nov. 1947.

12. Harrell, G. T.: Rickettsial involvement of the nervous system, The Med. Clinics of N. A., 37:395, March 1953.

13. Hodes, H. L.: Common types of encephalitis in children, N. Y. State J. Med., 50:227, Oct. 1950.

14. Hollister, A. C., Longshore, W. Allen, Dean, B. H., Stevens, I. M.: The 1952 outbreak of encephalitis in California—Some epidemiologic aspects, Calif. Med., 79:84-90, Aug. 1953.

15. Huntington, R. W.: Personal communication to the authors.

16. Lennette, E. H.; Nyberg, Marjorie; Barghausen, Dolores; Chin, Roland; Fujimoto, Francis; Itatani, Margaret: The 1952 outbreak of encephalitis in California—Laboratory methods for etiologic diagnosis, Calif. Med., 79: 78-83, Aug. 1953.

17. Lennette, E. H., and Longshore, W. Allen: Western equine and St. Louis encephalitis in man, Calif. Med., 75: 189-195, Sept. 1951.

18. Medovy, H.: Western equine encephalomyelitis in infants, J. of Ped., 22:311, Jan.-June, 1943.

19. Price, A. H.: The meningitides and encephalitides, The Med. Clinics of N. A., Nov. 1943.

20. Quong, T. L.: The pathology of western equine encephalomyelitis, Canad. Pub. Health J., 33:300, June 1942.

21. Reeves, W. C.: Personal communication to the authors.

22. Rivers, T. M.: "Viral and Rickettsial Infections of Man," 2nd ed., J. P. Lippincott Co., 1952.

23. Sawchuck, S., LaBoccetta, A. C., Tornay, A., Silverstein, A., and Peale, A. R.: Measles encephalitis—study of fifty cases, Am. J. Dis. of Child., 78:844, Dec. 1949.

24. Sulkin, S. E.: Human encephalitis due to the western equine encephalomyelitis virus, Texas State J. Med., 41:455, Jan. 1946.

25. Tichy, F. Y., and Baker, A. B.: Acute anterior poliomyelitis, The Med. Clinics of N. A., 37:363, March 1953.

26. Winkleman, C. W., and Gotten, N.: Encephalomyelitis following the use of serums and vaccines, Amer. J. Syph. and Neurol., 19:414, 1935.

The 1952 Outbreak of Encephalitis in California

Laboratory Methods for Etiologic Diagnosis

EDWIN H. LENNETTE, M.D., Ph.D., MARJORIE C. NYBERG, A.B.,
DOLORES M. BARGHAUSEN, A.B., ROLAND CHIN, B.S.,
FRANCES Y. FUJIMOTO, A.B., and MARGARET K. ITATANI, M.S., *Berkeley*

• The general procedures used in the diagnosis of neurotropic viral diseases are outlined and are discussed with specific reference to western equine encephalitis.

Cerebrospinal fluid is considered practically worthless as a starting material, in attempts to isolate the causal agent. The material of choice in attempting to recover the virus is central nervous system tissue, available only in instances of fatal infection. In the usual case, the diagnosis depends upon serologic or immunologic methods. These methods are aimed at detecting the presence of specific antibodies and of increases in the content of antibodies in the blood during the course of the illness.

The in vitro complement fixation test is considered a better diagnostic tool than the in vivo neutralization test, since rises in titer are more readily detectable by the former technique than by the latter.

THE TERM *infectious encephalitis* is a generic one, covering any encephalitic process resulting from the invasion of a microorganism. The etiologic agents, therefore, are diverse and of many biologic groups —protozoa, fungi, bacteria, rickettsiae and viruses. The similarity of the response of the encephalon to the noxious action of the agents is such, however, that on the basis of the clinical findings alone it is virtually impossible in the preponderance of cases to determine what the inciting agent might be; the assistance of laboratory examination is required.

Since the symposium of which this presentation is a part is concerned with the encephalitis of viral etiology, and specifically encephalitides due to the western equine virus, the present discussion will be limited to this aspect of infectious encephalitis. Referring again to diagnosis, and considering only the viruses, only comparatively seldom is it possible on clinical grounds alone to incriminate a specific member of this group. Thus, in post-infection encephalitides, it is generally assumed that the agent producing the precedent systemic illness is also responsible for the encephalopathic aftermath. (Controversial aspects of the etiology of post-infection encephalitis will not be considered herein.) Adequate inquiry into the patient's epidemiologic background, so frequently neglected, may give valuable leads to the true nature of the infection—for example, a history of recent exposure, in a case of primary mumps encephalitis, to a person who had mumps parotitis.

In the case of the arthropod-borne encephalitides, among which are included those due to the western equine and St. Louis viruses, the index of suspicion is heightened if the patient resides in or has recently traveled in an endemic area, or if an outbreak is occurring. Proof as to the exact identity of the causal agent, however, is something else again. During the past decade, a number of observers have discussed at length the difficulties of differential diagnosis, and Lennette and Longshore[6] summarized the situation two years ago. Kokernot, Shinefield and Longshore[5] now have restated the situation and illustrated the problems of differential diagnosis. All these studies have underlined the value of laboratory aid in reaching a specific etiologic diagnosis, and the unquestioned desirability of definitively determining the identity of the organism causing the disease if epidemiologic and clinical knowledge is to advance.

How are these ends to be reached? Of first importance is the need for close cooperation between clinicians and virologists. Unfortunately, the present situation on the whole leaves something to be desired in this respect. Only too often, to the despair of laboratorians, are materials submitted for examination without the information necessary for intelligent approach to the problem. Certainly, supplying only the name of the patient without any corollary personal, epidemiologic or clinical data, and requesting that accompanying specimens be submitted to "virus studies" is of no help whatever toward solution of the problem presented by this

From the Viral and Rickettsial Disease Laboratory, California State Department of Public Health, Berkeley.

Part of the Symposium on Encephalitis presented by the Section on Public Health at the 82nd Annual Session of the California Medical Association, Los Angeles, May 24-28, 1953.

all-inclusive request. Lacking the crystal ball of the seer or the necromancer, the laboratorian must either perform a whole battery of useless tests or obtain from the clinician the necessary lacking data. Since the former is so costly in terms of time, labor and reagents as to be prohibitive, the latter is the course almost invariably followed—even though it interposes delays in examination. Brief clinical summaries, of the type supplied with each specimen or set of specimens by physicians of the armed forces and the Veterans Administration, are of great help to laboratorians. On behalf of all laboratorians in general, and of virologists in particular, the authors make a plea that such summaries be supplied wherever possible; failing this, the "specimen history" form of the particular laboratory to which the specimens are to be sent should be completely filled in.

Next in importance is an adequate appreciation of what virologic examinations require in the way of materials for examination, the appropriate time and method of collecting these materials, and the ways of handling between the time of collection and arrival at a laboratory. The basic rules are simple and will be brought out in the appropriate connections as this discussion develops.

The diagnostic approaches available in the virus field can be categorized under three headings: isolation of the causal agent, serologic tests in vitro, and immunologic tests in vivo. These methods are all based on the fundamental principles of bacteriology and immunology, any differences in method being referable to the peculiar properties and characteristics of viruses as compared with bacteria. With this in mind, a brief outline of each approach would seem pertinent at this point. The remarks under the next three headings, although referring specifically to the encephalitides, are essentially applicable to all viral diseases.

Isolation of the causal virus. To weight the balance in favor of success, one must choose the material most likely to contain the virus; collect it at the proper stage of the illness; and subinoculate it into laboratory animals as promptly after collection as possible or, if this cannot be done, keep it frozen at dry ice temperature until subinoculation can be done. These are general principles which, in the case of the encephalitides, require some modification, and an explanation thereof.

Although in instances of central nervous system disturbance of bacterial origin it is possible to recover the organism from the spinal fluid, this material is essentially worthless when dealing with viral agents. The authors have never succeeded in isolating a viral agent from spinal fluid despite the testing of many hundreds of specimens. It is true that viruses have been recovered from spinal fluid, but generally only when the fluid has been injected into laboratory animals under ideal conditions practically within minutes of collection from the patient. Since many viruses are highly labile in what is generally referred to as "room-temperature," it is obvious that exposure to unfavorable temperatures for even relatively short intervals, as during the time required for a specimen to reach its destination through the mails, will result in destruction of the agent. Much of the authors' experience has been with such specimens, in transit anywhere from one to three days, and unprotected from the deleterious effects of heat. However, even in those instances in which spinal fluid has been shipped on dry ice, the experience has been no better. It is not known how such specimens have been treated (or maltreated) before they were shipped in the frozen state, but it has been concluded from experience that, for practical purposes, spinal fluid is not a good material from which to try to isolate a virus.

While the virus of western equine encephalomyelitis has been isolated from the blood, it would appear that the chances for success here are limited, since viremia, if it occurs, does so very early in the disease, usually before the patient seeks medical attention or before the nature of the illness is recognized by the physician. This leaves, in essence, only those tissues which are the site of predilection of the virus—tissues of the central nervous system—as the material from which the virus can be recovered. Obviously, this applies only to cases in which the patient dies. Even with such presumably auspicious starting material, the virus cannot always be isolated. If the infection is a fulminating one, and death occurs early, the virus may be expected to be present in concentrations that, if not actually high, are at least detectable. As the duration of the illness lengthens, the chances for recovery of a virus diminish progressively and eventually, if sufficient time elapses, become nil. It is apparent, therefore, that failure to recover a virus is of no diagnostic value—that is, a "negative" result is not conclusive that a virus was not present.

In excising central nervous system material for virus isolation procedures, portions of several representative areas should be taken. These should be placed individually into separate containers, frozen at once, and sent to the laboratory on dry ice. As the material is to be injected into laboratory animals, great care should be taken against bacterial contamination. Unfortunately, the brain is seldom removed with aseptic precautions, which in itself gives rise to difficulties when such contaminated tissues are injected into the cranial cavity of the test animal, and the difficulties are compounded or

made insurmountable if the specimen is removed by hands which have just opened the intestinal tract.

It is highly desirable that a specimen of blood be obtained at the time material is taken from the central nervous system. This serves a dual purpose. If the interval between the onset of illness and death has been long enough to give the defensive mechanisms of the body an opportunity to come into operation, humoral antibodies may have appeared. Consequently, the postmortem blood specimen, especially if tested in conjunction with a specimen taken earlier in the illness (vide infra), may be useful either in establishing a diagnosis or to show that the agent recovered from the patient is related to the illness, and is not an extraneous one.

Serologic tests. These are best exemplified by the complement-fixation technique, which has been used for some years. The earlier procedures, while highly useful in experienced hands, were fraught with difficulties and, to the unwary or to the novice, with danger because of the troublesome non-specific effects and because of the very low antibody titers detectable with the comparatively insensitive antigens. These problems were associated with the crudeness of the antigen preparations which were, in essence, raw suspensions of infected mouse brain, subjected to several cycles of freezing and thawing to precipitate out some of the factors giving rise to non-specific fixation.[1] Within recent years these mouse brain antigens have been considerably improved by extraction of the material, either in the aqueous phase or in the lypholized state, with lipid solvents to remove the undesirable fractions.[3, 4] The authors find these extracted antigens satisfactory and employ them routinely except where (in their experience) antigens derived from infected embryonated hens' eggs have proved to be superior, or at least as good. Thus, since the St. Louis virus does not multiply to a sufficiently high concentration in the embryonated egg to give a good starting material, an extracted mouse brain antigen is used. But since the western equine encephalomyelitis virus, in contrast, grows to as high a titre in the egg as in the mouse, complement-fixation antigen used in tests for that virus is prepared from infected egg materials. The virus strain used is one originally isolated, in embryonated eggs, from the brain of a horse. It produces an excellent antigen. The egg membranes and fluids are used, and non-specific factors are removed from the preparation by high speed centrifugation.

Sabin and co-workers,[2, 7] through a series of painstaking investigations, recently developed a hemagglutination-inhibition test for the western equine and St. Louis viruses. The procedure is rather complicated and demands exacting control at every step, but promises to be a highly useful investigative and diagnostic tool. The authors have had so little experience with this procedure that they cannot make any evaluations at present. The following remarks, however, are as pertinent to the use of the hemagglutination-inhibition method as to the complement-fixation method.

In any method whose primary purpose is to detect antibodies, a single determination has little or no value from a diagnostic standpoint. The objective in diagnostic work is to determine whether, during the course of illness, specific antibodies develop in the patient, or whether, if antibodies are already present early in the illness, they rise to a significantly greater level. Hence at least two specimens of blood are necessary for examination, one taken as soon as possible after the onset of the illness, the other some days later. Results obtained in tests of the first specimen serve as a base line against which the results obtained with subsequent specimens are compared and interpreted. The need for a base line becomes obvious if it is recalled that many persons living in endemic areas have antibodies to western equine encephalomyelitis virus which were acquired through inapparent, or subclinical, infections. Through stimuli provided by repeated exposures, these antibodies may persist for relatively long periods. To make a diagnosis of encephalitis in an ill person on the basis of an antibody determination conducted on a single specimen of blood taken during the acute phase of illness obviously is not permissible. The basic operating principle, then, is the examination of at least two, sometimes more, specimens, the interval between withdrawal of them being of sufficient length (seven to ten days) to permit development of detectable increases in antibody level.

Immunologic tests. The so-called neutralization test, as the name implies, determines the ability of the serum under examination to neutralize the lethal effects of the virus. The test is performed by adding some of the serum to each of a series of tubes containing virus in decreasing amounts. Each of the serum-virus mixtures thus obtained is injected into mice and the animals are kept under observation for 10 to 14 days. If the serum contains specific antibody, the virus, unless excessive amounts are present in the mixture, is neutralized, and the animals survive. Conversely, if antibody is absent, the virus is unaffected, and kills the animals. If the serum contains only small amounts of antibody, only small amounts of virus are neutralized, and consequently, only those animals receiving mixtures containing minimal doses of virus survive. If large amounts of antibody are present, correspondingly larger doses of virus are neutralized, which is manifested by the

TABLE 1.—*Clinical conditions suspected, as stated on forms accompanying blood specimens to laboratory*

1. Arthropod-borne encephalitis
2. Coxsackie encephalitis
3. Meningitis
4. Meningitis, encephalitis
5. Mumps encephalitis
6. Neurotropic virus infection
7. Poliomyelitis
8. Poliomyelitis or encephalitis
9. Respiratory disease with encephalitis
10. Rickettsiosis with encephalitis
11. Viral encephalitis
12. Western equine encephalitis

survival of animals that received test mixtures containing increasingly larger amounts of virus. From the number of animals dying or surviving in the test, the neutralizing capacity of the serum can be computed and expressed as a number.

Since neutralizing antibodies, unlike complement-fixing antibodies, persist for years, the need for examining multiple specimens of the patient's blood is even greater; the mere presence of antibody is without significance, and a rise in titer must be demonstrable before a laboratory diagnosis can be made.

All specimens of blood should be taken with aseptic precautions, and put into a sterile container, since bacterial contamination not only renders the serum unfit for serologic tests, but also precludes its use in neutralization tests. Anticoagulants and preservatives should not be used, and freezing of whole blood must be avoided, as laked blood cannot be used in serologic tests. Whole blood should be shipped without refrigeration. (See details of method in adjoining column.)

Collection of Blood Specimens for Serologic Tests for Encephalitis

1. Obtain 10 to 20 ml. of venous blood as soon as there is clinical suspicion of encephalitis. (The specimen should be taken as soon as possible after the onset of illness.)
2. Ten to 14 days later, obtain a second 10 to 20 ml. specimen of blood. (This is the recovery-phase or convalescent-phase specimen.)
3. Send each specimen to a virus laboratory immediately after it is obtained.

Procedure for Taking and Shipping Specimens

1. Blood should be taken with a *dry* sterile syringe and needle. Do not use anticoagulants.
2. Put the specimen into *sterile* tubes closed with sterile rubber or cork stoppers. Use *aseptic precautions* throughout. Do not add preservatives to the blood.
3. Be sure tubes are tightly stoppered for shipment. Do not ship tubes closed with cotton plugs.
4. Virus laboratories supply mailing containers and sterile specimen tubes on request. Also supplied with these is a "specimen history" form. This must be completely filled in and submitted with the specimen. Inadequate information will delay testing of your material.
5. Mail specimens and history to virus laboratory. Two laboratories in California offer diagnostic facilities:

CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH
Viral and Rickettsial Disease Laboratory, 1392 University Avenue, Berkeley 2 (BErkeley 7-3712)

and

CITY OF LOS ANGELES DEPARTMENT OF HEALTH
Viral and Rickettsial Disease Laboratory, 10975 Wilshire Boulevard, Los Angeles 24, (ARizona 8-2016)

EXPERIENCES DURING THE 1952 OUTBREAK

Early in the summer of 1952, several factors suggested that an unusual incidence of encephalitis in California might be in the offing: The number of cases of encephalitis being reported by physicians was higher than in the corresponding periods of past years, the number of specimens being received by the laboratory from patients with disturbances of the central nervous system was higher, and the proportion of cases in which results of laboratory examination were positive for encephalitides was unusually high.

The clinical impressions, as reported on the "specimen history" forms submitted with specimens sent to the laboratory, covered a rather wide spectrum but the preponderance fell into the designations listed in Table 1. In virtually all the cases of laboratory-proved western equine encephalitis, the clinical impression was of one or another of the 12 conditions listed. Since there is no simple, practical diagnostic test for poliomyelitis, it appears that many of the specimens submitted from patients on whom the clinical impression was given as poliomyelitis were sent in primarily to rule out infection with the arthropod-borne encephalitis viruses. As awareness of the outbreak increased, increasingly larger numbers of specimens were submitted from patients considered to have "viral encephalitis" or western equine encephalitis. The large number of laboratory-proved cases of western equine encephalitis was owing in part to the cooperation of physicians who, interested in obtaining a definitive diagnosis, sent in the large amount of material that was examined; and in part to the practice of this laboratory of applying a battery of tests to all specimens sent in from patients with clinical evidence of a central nervous system disturbance (all blood specimens are routinely tested against the viruses of western

equine encephalomyelitis, St. Louis encephalitis, lymphocytic choriomeningitis, herpes simplex, and mumps).

Material from more than 1,500 patients was examined during the summer months, and infection with western equine virus was proved in 370 cases and with the St. Louis virus in 44 cases. In 356 of the 370 cases of western equine encephalitis the diagnosis was made by the complement fixation method, in nine by the neutralization test and in five by isolation of the virus from specimens of the central nervous system (see Table 2). (In addition to the cases of western equine and St. Louis encephalitis, there were a number of cases in which encephalitis was proved to be caused by the mumps virus, and two cases in which the herpes simplex virus was found to be the infecting organism.)

Perusal of part of the large amount of laboratory data accumulated during the 1952 experience raised some provocative questions and suggested answers to certain aspects of infection with the western equine encephalomyelitis virus. Since many laboratory results are being rechecked and additional work is being done, and since final collation and statistical evaluation of the data has yet to be done, some of the following generalizations should be accepted with the understanding that they represent only tentative conclusions or indicate trends; the definitive findings will be published later as final evaluation of the pertinent data is reached.

Table 2 present a comparison of the results obtained by the complement fixation and neutralization methods for western equine encephalitis; only data on cases in which a diagnosis could be made by one or the other method are given. Considering first the complement fixation test, it will be seen that by this method a laboratory diagnosis was made in 356 cases. In the preponderance of cases, the diagnosis was made on the basis of a four-fold or greater rise in antibody titer between the blood taken in the acute phase and a specimen or specimens taken in the recovery or convalescent phase. In 257 cases, the titer of the acute phase serum was less than 1:8 —that is, "negative"—and subsequently rose to at least 1:16 (four-fold) and usually higher (as high as 1:256 or greater). In other cases the initial titers were 1:8 or higher and later rose to at least four times higher, the minimal increase considered diagnostically significant; and in a few cases the diagnosis was based on the presence in the serum of high levels of complement-fixing antibody. The crude data available indicate that, in general, the longer the interval between onset of illness and the drawing of the first specimen of blood, the higher the titer. In some instances the fact that there was no rise in titer between the first and subsequent specimens was owing to the fact that the antibody concentration had already reached its maximal level by the time the first specimen was taken. However, in some persons complement-fixing antibody may be slow in developing or appearing; in several cases there was no rise in titer until after a number of specimens of blood, taken at intervals during the illness and the recovery phase, had been tested.

TABLE 2.—*Comparison of results obtained by the complement fixation and neutralization tests for western equine encephalomyelitis*

Results of complement-fixation tests	Results of neutralization tests			
	Positive	I or N*	No test	Totals
Positive	64	277	15	356
I or N	9			9
Totals	73	277	15	365†

* I or N = Inconclusive or Negative.

† Diagnosis in five additional cases made by isolation of virus from central nervous system.

From the diagnostic standpoint, it is of value to know how long complement-fixing antibodies persist after illness. If they disappear rapidly, especially between one encephalitis season and the next, the mere presence of antibodies in the blood might serve as evidence of recent infection. Studies are currently in progress to determine how long and at what levels complement-fixing antibodies to the western equine virus persist. Antibody determinations have been made on a number of persons six to nine months after illness, and the results apparently indicate differences in antibody persistence between infants and persons beyond infancy. The antibody levels in children who were one year or less of age at the time of illness tend to persist at the original level up to at least seven months; in persons older than that, however, the levels at the time of last testing, some seven months after the acute phase of disease, appeared to be declining rather quickly, and in some persons antibody was no longer demonstrable.

As is noted in Table 2, in only nine cases was diagnosis made on the basis of the neutralization test alone. In those cases, the results of complement fixation tests were negative, or the titer of fixation was so low that it was regarded as non-specific, or the test could not be done because the specimens of serum were strongly anticomplementary. In 64 cases the results of the complement fixation test and the neutralization test were in agreement, in that the findings by either method could be interpreted as evidence of western equine virus infection. In 277 other cases, however, the results of the neutralization test had to be regarded as negative or inconclusive, although a diagnosis of western equine encephalitis was made in all those cases by means of the complement fixation technique.

As was previously noted, the neutralization test consists of determining the capacity of acute phase

serum, and then of recovery or convalescent phase serum to neutralize the lethal effect of the virus for animals (mice). Each specimen of serum is tested against graded doses of virus, so that the amount of antibody present in each specimen can be determined in terms of the quantity (number of lethal doses) of virus neutralized. Since, during the course of a patient's illness, specific antibodies are expected to appear or, if already present at the time the first specimen was obtained, to rise in titer subsequently, a significant rise in neutralizing antibody titer would provide a laboratory diagnosis. The neutralizing capacity of serum is indicated in terms of the number of lethal doses (50 per cent end-point) neutralized. That capacity is expressed as an arithmetic or a logarithmic number. The difference between the neutralizing capacity of acute phase serum and that of convalescent phase serum is referred to as the "neutralization index." There is some division of opinion as to what constitutes a significant neutralization index, but since the virus dilutions used in the tests are prepared in 10-fold steps, a possible variation of one 10-fold dilution in the test results is generally regarded as within the possibility of error in the test. Consequently, a neutralization index of 1.0 logarithm, representing a 10-fold rise in titer, is considered not significant. The authors have taken a neutralization index of 1.5, or a 30-fold increase, as representing the minimal difference in titer between an acute and a convalescent phase specimen that can be regarded as diagnostically significant. This comprises a very small change in titer, yet on the basis of this criterion it was necessary to relegate the results in 277 cases (that were "positive" by complement fixation methods) into the negative or inconclusive category so far as the neutralization test was concerned. The difficulty lay not in demonstrating that the patients had neutralizing antibodies, since all did, and many had sera with capacity to neutralize 1,000 or even 10,000 lethal doses, but in showing that the difference in neutralizing capacity between acute and convalescent sera amounted to 1.5 logs or more. The crux of the difficulty resides in the fact that, if these persons can be considered as representative of patients with western equine encephalitis who seek medical attention, in the great majority (277 of 341, or 81 per cent, in this series) neutralizing antibodies not only are present by the time the first specimen of blood is taken, but have already reached their maximal level. Since in a high proportion of cases the first blood specimens were taken within only a few days after the onset of the illness, it appears that neutralizing antibody is formed rapidly, and perhaps may be appearing even before the advent of clinical symptoms. Whatever the situation may prove to be, the present experience indicates that under conditions of every-day practice, neutralizing antibodies are already present in high concentration by the time the first specimen of blood is taken for examination, whereas little or no complement-fixing antibody is present. Consequently, the authors are inclined to favor strongly the complement fixation method over the neutralization test as a diagnostic tool for western equine encephalitis, and in the future plan to rely on it as the basic diagnostic method. This attitude is without prejudice to the hemagglutination-inhibition technique, which is relatively new and whose applicability to practical, large-scale diagnostic work has yet to be assessed.

1392 University Avenue.

REFERENCES

1. Casals, J.: Complement fixation test with encephalitis viruses, J. Immunol., 56:337-341, Aug. 1947.

2. Channock, R. M., and Sabin, A. B.: The hemagglutinin of St. Louis encephalitis virus, J. Immunol., 70:271-285, 286-301, 302-316, March 1953.

3. DeBoer, C. J., and Cox, H. R.: Specific complement-fixing diagnostic antigens for neurotropic virus diseases, J. Immunol., 55:193-204, Feb. 1947.

4. Espana, C., and Hammon, W. McD.: An improved benzene-extracted complement fixing antigen applied to the diagnosis of the arthropod-borne virus encephalitides, J. Immunol., 59:31-44, May 1948.

5. Kokernot, R. H., Shinefield, H. R., and Longshore, W. A., Jr.: The 1952 outbreak of encephalitis in California—Differential diagnosis, Calif. Med., 79:73-76, Aug. 1953.

6. Lennette, E. H., and Longshore, W. A., Jr.: Western equine and St. Louis encephalitis in man, California, 1945-1950, Calif. Med., 75:189-195, Sept. 1951.

7. Sabin, A. B.: Hemagglutination by viruses affecting the human nervous system, Fed. Proc., 10:573-578, June 1951.

The 1952 Outbreak of Encephalitis in California

Epidemiologic Aspects

ARTHUR C. HOLLISTER, JR., M.D., M.P.H.,
W. ALLEN LONGSHORE, JR., M.D., M.P.H.,
B. H. DEAN, D.V.M., M.P.H., and IDA MAY STEVENS, M.A.P.H., Berkeley

• For the most part, epidemiologic phenomena observed in the outbreak of encephalitis in 1952 accorded with patterns that had been apparent in previous years. Ninety-seven per cent of the 414 laboratory-confirmed cases of western equine and St. Louis encephalitis in humans occurred in the 20 Central Valley counties. The cases of western equine encephalomyelitis in horses were generally scattered over the state. In the Central Valley most of the cases in horses were in animals less than two years of age; elsewhere the incidence was higher in older horses.

There were no laboratory-confirmed cases of western equine or St. Louis encephalitis in humans earlier than June or later than October.

In 1952 there were far more cases of western equine than of St. Louis encephalitis—a departure from the pattern in the previous seven years when there were about as many of one as of the other. No known satisfactory index is available for the prediction of the extent or type of outbreaks in humans.

Approximately one-third of the cases of western equine encephalitis were in patients less than one year of age, whereas there were no cases of the St. Louis disease in patients that young.

The incidence of western equine encephalitis in persons under 5 years of age was about the same for girls as for boys. In higher age brackets, males with western equine encephalitis outnumbered females 2 to 1. The corresponding ratio for St. Louis encephalitis was only 1.2 to 1.

CALIFORNIA EXPERIENCE with western equine and St. Louis encephalitis in man for the period 1945-1950 has been set forth in some detail by Lennette and Longshore,[4] and a general description of the 1952 outbreak has likewise appeared in print.[2] The purpose of this presentation is to touch on some of the epidemiologic highlights of the 1952 epidemic. It will not attempt to discuss either the environmental and climatic conditions, which were in a large measure responsible for the unusually heavy incidence in 1952, or the measures taken to control the outbreak. These factors and aspects are covered by Stead and Peters.[8]

The rather extensive epidemiologic data available for analysis were made possible by the assistance rendered by personnel assigned to California by the Communicable Disease Center of the United States Public Health Service, and through the cooperation of local health agencies and practicing physicians in the affected areas of the state.

The 1952 incidence of 805 cases of encephalitis in humans was the highest ever known in California. The total number of infectious encephalitis cases considered to be in the outbreak, and reported during the period June through October, was 792. Of these, 370 were confirmed by laboratory procedures as western equine encephalomyelitis and 44 as St. Louis encephalitis, making a total of 414 laboratory-confirmed cases (see Lennette and coworkers[5]). In 1950, the year of second highest incidence, the total number of cases was 357 of which 157 were confirmed; and in 1945, when the incidence was third highest, 54 of the 302 reported cases were laboratory-confirmed.

During the period May through November 1952, there were 407 cases of encephalitis in horses reported. Although the laboratory received specimens in relatively fewer of the cases in horses than of the cases in humans, 73 of the 407 were confirmed as western equine encephalomyelitis, and these occurred from June through September.

From the Bureau of Acute Communicable Diseases, California State Department of Public Health, Berkeley.

Part of a Symposium on Encephalitis presented by the Section on Public Health at the 82nd Annual Session of the California Medical Association, Los Angeles, May 24 to 28, 1953.

GEOGRAPHIC DISTRIBUTION

Figure 1 shows the geographic distribution by county of the 805 cases of infectious encephalitis reported in 39 of the 58 California counties in the calendar year 1952. Figure 2 shows the areas report-

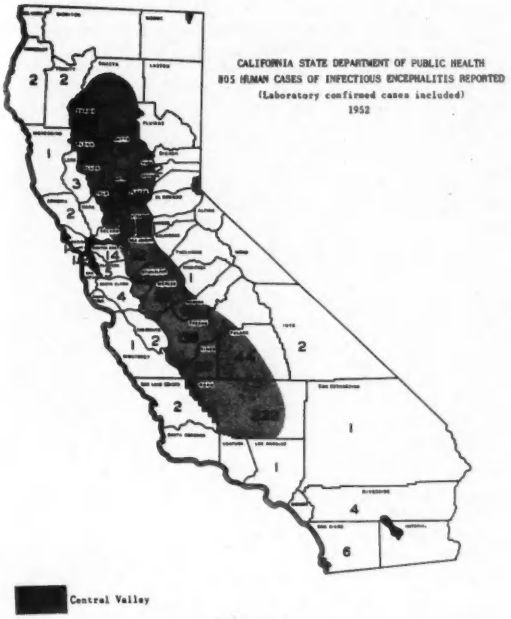


Figure 1

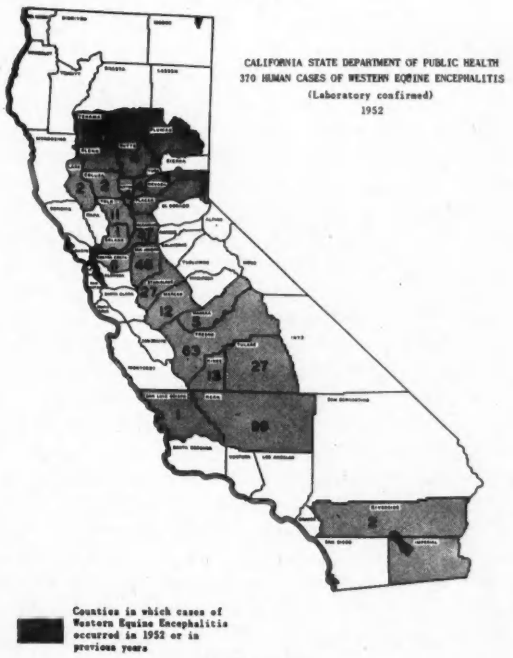


Figure 2

Figure 3

Figure 4

ing confirmed western equine encephalitis and Figure 3 those reporting confirmed St. Louis encephalitis. Twenty-three counties, predominantly those in the Central Valley, had laboratory-confirmed cases: 11 counties had western equine cases only, three St. Louis only, and nine had both types. Four counties had confirmed cases of western equine for the first time while three counties had their first confirmed cases of St. Louis encephalitis. Five of the counties in which cases were reported had not had any confirmed cases until 1952. These were: Mariposa, Nevada, Contra Costa, San Luis Obispo, and San Diego.

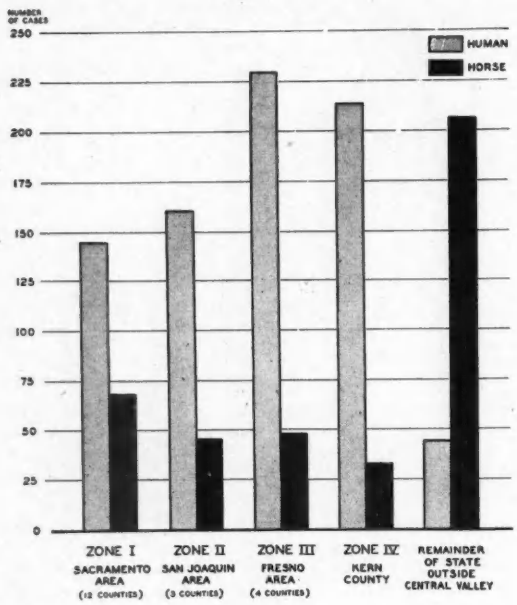


CHART 1

The pronounced differences in the ratio of cases in humans to cases in horses in the valley and in the "fringe areas" are shown in Figure 4 and Chart I. The major difference noted in the distribution of the human and the horse cases was that the majority of the human cases were rather definitely limited to the Central Valley area whereas the horse cases were generally scattered throughout the state. During the 1952 epidemic, approximately as many cases of encephalitis in horses were reported in some of the so-called "fringe counties" as in the endemic areas. This may have been due to the possibility that a large percentage of the horses in the endemic areas either had immunity due to exposure in previous years or had been vaccinated, whereas in the "fringe areas" a higher percentage of the horses were probably susceptible and vaccination in those areas was not started until actual cases were reported. In the endemic areas, most of the cases occurred among horses up to two years of age while those that occurred in the "fringe areas" were in older horses, suggesting that the older animals in the endemic areas had been exposed and had developed immunity whereas those in the "fringe areas" had not been exposed previously and were not immune.

The disease in horses follows an epidemiologic pattern similar to that in man. Very rarely does more than one case occur on any one ranch although there may be 10 to 20 other horses there. The cases occur sporadically and at widely scattered places.

TABLE 1.—*Reported human and equine cases of infectious encephalitis—month of onset by geographic zone of exposure—California, May-October 1952*

	Total	May	June	July	Aug.	Sept.	Oct.
Total							
Human	797	5	43	329	296	96	28
Horse	406	4	100	160	118	16	8
Zone I							
Human	146	..	1	39	87	15	4
Horse	70	2	53	15	....	....	....
Zone II							
Human	160	..	4	70	72	12	2
Horse	46	..	2	35	8	....	1
Zone III							
Human	230	..	9	105	75	32	9
Horse	48	..	10	27	10	....	1
Zone IV							
Human	217	3	28	104	42	30	10
Horse	33	..	22	6	5	....	....
Fringe Counties							
Human	44	2	1	11	20	7	3
Horse	209	2	13	77	95	16	6

Zone I—Sacramento area (12 counties).
Zone II—San Joaquin area (3 counties).
Zone III—Fresno area (4 counties).
Zone IV—Kern County.
Fringe counties—remainder of State outside Central Valley.

The transmission of the virus from horse to horse, horse to human, or human to horse has not been established. It has been stated that the usual sequence is that horse cases will occur one to three weeks before the onset of cases occurring in humans (see Table 1). This relationship has not been found to be uniformly true in California since in some instances human cases are reported first, while in others cases have been reported in both humans and horses at approximately the same time, with no definite pattern established. Usually the horse cases occur early in the southern area and then extend northward as the summer progresses; however, this is not always the pattern, as cases have been reported as far north as Tehama County earlier than in the southern San Joaquin Valley counties. In 1952, a large number of horse cases were reported in Riverside County late in August when horse cases were receding in the San Joaquin Valley.

An experimental study developed from the opinion held by many investigators that a horse ill with western equine encephalomyelitis is a hazard to humans in his vicinity. This study[1] showed that a horse inoculated with the western equine virus developed viremia as early as 24 hours after inoculation and in some cases the viremia lasted up to five days. Approximately seven to nine days after the horse was inoculated and four days after viremia was no longer present, rises in temperature were noted and about the tenth or eleventh day the horse became clinically ill. The fifth day following inoculation, the virus could be found only in the brain tissue. This indicated that the infected horse did not present any hazard to people or to other

horses after the appearance of the signs of clinical illness. It also demonstrated that since the viremia lasted up to five days, mosquitoes theoretically could bite the horses during this five-day period and in turn possibly transmit the disease to other horses or humans. This point is far from completely settled.

In a serologic survey approximately 30 to 40 per cent of the horses two years of age or older in the San Joaquin Valley showed evidence of St. Louis antibodies. Despite efforts over a period of years, no one has found a horse under natural conditions with clinical illness due to the St. Louis virus. Therefore, until proven otherwise, it is believed that under natural conditions the St. Louis virus does not cause clinical illness in horses.

There is no clear-cut explanation of the difference in the geographic distribution of human and horse cases, although several hypotheses have been put forth. One possibility is that, since high mean temperatures such as those in the Valley areas apparently are necessary for the development of the virus and its multiplication in mosquitoes, mosquitoes in coastal counties and other areas where high temperatures are not maintained would usually be noninfective. Another hypothesis postulates the presence of a non-mosquito vector that has a preference for horses and that could transmit the disease to horses in the "fringe areas," whereas within the Valley the mosquito species is the primary vector for both man and horse. However, adequate epidemiologic study of outbreaks among horses in the "fringe areas" may confirm the suspicion that most of the cases among the horses in these outer areas are in small valleys where the climatic conditions and mosquito prevalence fit the Central Valley pattern but neither the surrounding mosquito vector reservoirs nor human population provide sufficient exposures to give rise to cases in humans.[7]

TABLE 2.—Cases of infectious encephalitis reported by counties and zones—California, 1952

County	1950 Population	Total Cases—Number	Total Cases—Rate
California, Total	10,586,225	805	7.6
Central Valley, Total	2,097,204	758	36.1
Zone I:			
Butte	64,930	9	13.9
Colusa	11,651	2	*
Glenn	15,448	1	*
Placer	41,649	4	*
Sacramento	277,140	65	23.4
Shasta	36,413	.....	.....
Solano	104,833	8	7.6
Sutter	26,239	16	61.0
Tehama	19,276	1	*
Yolo	40,640	20	49.2
Yuba	24,420	11	45.0
Total, Zone I	662,639	137	20.7
Zone II:			
Contra Costa	298,984	14	4.7
Merced	69,780	26	37.2
San Joaquin	200,750	92	45.8
Stanislaus	127,231	42	33.0
Total, Zone II	696,745	174	25.0
Zone III:			
Fresno	267,515	138	51.6
Kings	46,768	22	47.0
Madera	36,964	21	56.8
Tulare	149,264	44	29.5
Total, Zone III	509,511	225	44.2
Zone IV:			
Kern	228,309	222	97.2

* Number of cases too small for rate computations.
Note: Rates per 100,000 population (1950 Census).

INCIDENCE

When the rate of incidence in humans is calculated for the Valley counties in the four zones, it is evident that the highest rate was in Zone IV (Kern County) where it was 97 per 100,000 population. Second was Zone III (Fresno, Kings, Madera and Tulare counties) where the rate was 44 per 100,000. In Zone II (San Joaquin, Merced, Stanislaus and including Contra Costa County) it was 25 per 100,000, and in Zone I (Butte, Colusa, Glenn, Placer, Sacramento, Shasta, Solano, Sutter, Tehama, Yolo and Yuba) it was only 20 per 100,000. Zones I, II and III are about equal in population, while the population of Zone IV is about one-third that of the other zones. If counties in the zones are considered individually, more variation in population, in number of cases and in rate of incidence is noted, as shown in Table 2.

The rate of incidence of encephalitis in infants less than one year of age varied considerably from zone to zone: It was 102 per 100,000 in Zone I, 290 in Zone III, 377 in Zone IV and 406 in Zone II. In all zones the rate of incidence in infants was higher than in persons of any other age group.

Even though large numbers of horses are vaccinated each year, which should bring about a reduction of the proportion susceptible to the disease, the rate of incidence was much higher in horses than in humans. This may be explained on the basis that horses are either more susceptible to the disease or that they have a greater exposure both as to the number of vectors and the area of unprotected skin. The incidence in California in 1952 was 384 per 100,000 horses (estimated).

SEASONAL PATTERN

The seasonal pattern of incidence in both humans and horses was essentially the same in 1952 as that observed in the preceding ten years. The incidence of western equine encephalitis in humans for the

state as a whole ranged from below ten cases a week for the first three weeks of June to a peak of over 100 cases a week in July, then receded to fewer than ten cases a week following the second week in October.

Fifty-three per cent of the western equine cases occurred in July, 60 per cent of the total for the year having occurred by the end of that month—this before any emergency mosquito control measures were put into effect. Ninety-four per cent of the western equine cases had occurred by the end of August, whereas only 20 per cent of the St. Louis cases had occurred up to that time. Fifty-two per cent of the St. Louis cases occurred in September.

Although specimens from patients with the encephalitis syndrome are tested at the laboratory at all times of the year, laboratory-confirmed cases of either type have not been recognized outside this June through October period of activity (with the exception in 1952 of an equivocal case with onset November 15).

The horse cases followed the same general seasonal pattern. The peak for the state as a whole was 160 cases, in July. In the Sacramento area and the Kern area the peak was recorded during June.

Once again the difference in seasonal pattern between western equine and St. Louis encephalitis in humans was noted. The first cases of laboratory-confirmed western equine had onset in June. The incidence reached a peak in July, decreased slightly in August and sharply in September. Confirmed cases of St. Louis type began in July; the peak was reached in September and there were a few scattered cases in October.

The ratio of cases of the western confirmed to St. Louis confirmed alternated irregularly during the eight years 1945-1952. In four of the years there were more western equine than St. Louis cases, and in the other four the converse, with no pattern of either sequence or alternation. Hence there is no basis for prediction as to which virus will predominate. Until 1952 there were no great differences between the number of western and the number of St. Louis cases in any year except 1947 when the ratio was 5 to 1.[4] In 1952, however, the ratio of confirmed cases of western equine to confirmed cases of St. Louis encephalitis was about 8 to 1. Also it should be noted that the number of confirmed cases of St. Louis encephalitis in 1952 was the second highest in the last eight years, the total of 44 cases comparing with the record high of 69 cases in 1950. This raises question as to whether mosquito control measures begun in August of 1952, specifically directed toward the Culex tarsalis mosquito, might not have reduced the number of vectors too late to have much effect on the outbreak of western equine encephalitis but soon enough, in

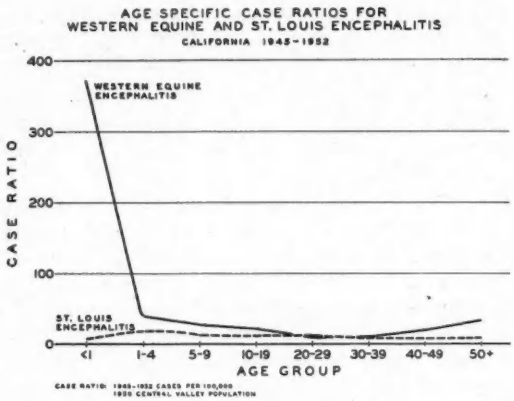


CHART 2

light of the difference in seasonal incidence, to hold the number of cases of the St. Louis disease to less than it might have been. In other words, without the control measures, would the incidence of St. Louis encephalitis and western equine encephalitis have been about equal, as in preceding years?

Upon analysis of another facet of seasonal data for 1952, it was noted that the peak of incidence of western equine encephalitis in humans occurred earliest in the southern part of the Central Valley, later in the mid-central and then in the northern central portions of the Valley. In 1952 for the first time cases occurred in sufficient numbers to demonstrate this phenomenon. This progression northward is probably owing to progression of climatic changes, not to a migration of infected mosquitoes or a movement of infected persons up the Valley.

AGE DISTRIBUTION

In all areas in which western equine encephalitis occurred, the incidence was far higher in infants less than one year of age than in any other age group (Chart 2). Approximately one-third of all patients were in that age bracket, and 94 per cent of those in that group were under seven months of age.

In 1952 there were no cases of St. Louis encephalitis in persons less than a year of age; and of the 213 confirmed cases of the disease in California in the eight years 1945-1952, only three (1.4 per cent) were in patients in that age bracket, whereas 29 per cent of all cases of western equine encephalitis were in the lowest age group. Studies are under way to explore the possibility that (1) antibodies for the St. Louis virus are more effectively transmitted from mother to fetus than are western equine antibodies, or that (2) many more mothers are immune to St. Louis than to the western equine virus.

SEX AND RACE

Of the 792 cases of infectious encephalitis reported in the period June through October 1952,

TABLE 3.—*Results of tests to determine number of subclinical cases of St. Louis or western equine infection in members of family of patient with disease*

	No. Persons Tested	Laboratory Results		
		Negative	Antibodies Present*	Unsatisfactory Tests
Zone I, Sacramento area (12 counties)	259	248	10	1
Zone II, San Joaquin area (3 counties)	361	342	9	10
Zone III, Fresno area (4 counties)	10	9	1	....
Zone IV, Kern County	55	53	....	2
"Fringe" counties outside Central Valley	4	3	1	....
Total	689	655	21	13

* For western equine. In no instance was there laboratory evidence of St. Louis virus antibodies.

535 were in males and 257 in females, a ratio of about two to one. This difference, previously observed, has been attributed by many investigators to the greater occupational hazards and exposure of males. In laboratory-confirmed cases of western equine encephalitis the ratio was about the same as for all cases of encephalitis reported—there were about twice as many male as female patients—but in the smaller series of confirmed cases of St. Louis encephalitis the ratio of males to females was only 1.2:1.

In the western equine infections, the difference in incidence by sex was pronounced in persons 5 years of age and older, but there was little if any difference in children under 5 years old. Of 31 patients in the 5 to 9 age group with proved western equine infection, 27 were boys and 4 girls—a disparity that can hardly be explained as owing to occupational factors.

Of the 792 cases reported, 708 were in white persons, 53 in non-whites and 31 in persons whose race was not reported.

SPECIAL SURVEYS

An attempt was made to determine the number of subclinical cases occurring in the family of a person with a proved case. Specimens of blood were taken from all persons in the same household with patients who had proved cases of either St. Louis or western equine encephalitis and the specimens were tested for the presence of antibodies which might indicate recent or previous infection with either of the viruses. The results (Table 3) may be interpreted to indicate that multiple clinical cases in a family are unusual even though members of the family other than the patient rarely exhibit antibodies in their blood.

Specimens of blood were submitted for laboratory tests in 91 per cent of the cases reported as encephalitis. But since there were many cases of clinical encephalitis in which laboratory tests for the etiologic agent were negative, there seems to be reason for strong surmise that viruses as yet unrecognized produce this familiar syndrome. The observation of some patients who had clinical symptoms typical of encephalitis but who had negative results of serology at the usual 10 to 14 day interval, brought about a special study of blood specimens obtained over a longer period. Additional cases were confirmed in the older age groups by this procedure.[3, 6]

At present, not often is suspicion of encephalitis aroused unless there are symptoms of central nervous system involvement. However, at two hospitals effort was made to get specimens of blood from all persons entering with fever; and in two cases in which the only symptom besides fever was diarrhea, serologic tests showed significant titer rises for the western equine virus. While the series on which the study was made was small, the results gave some cause for considering extension of the scope of suspicion to include symptoms other than those referable to the central nervous system. Further studies are indicated.

FATAL CASES

Of the 805 patients with reported infectious encephalitis in 1952, 52 died, a case fatality rate of 6.4 per cent. This compares very favorably with fatality rates in previous years when the number of cases was much smaller: 8.3 per cent in 1951, 8.9 per cent in 1950, 20.0 in 1949 and 42.3 in 1948. The 52 deaths in 1952 were, after investigation, ascribed to encephalitis, but in many instances the etiologic agent was not determined. The decline in case fatality rate may be the result of a combination of improved supportive therapy, better case finding, and changes in death recording.

Autopsy was carried out in 36 of the 52 fatal cases in 1952. In only 14 cases were specimens of the brain submitted to the Virus Laboratory in Berkeley. Western equine encephalitis virus was isolated from 5 of the 14, and 9 were reported as negative for western and St. Louis viruses. (Herpes virus was isolated from two and Coccidioides immitis from one of the specimens that were negative for the St. Louis and western equine viruses.)

Emphasis is needed on the desirability of submitting adequate autopsy specimens for viral tests.

2180 Milvia Street.

ACKNOWLEDGMENTS

The authors wish to acknowledge the assistance given by the following physicians and veterinarians from the Communicable Disease Center of the United States Public Health Service in the collection of epidemiologic data during the 1952 outbreak: Jules Amer, M.D., William Clark, M.D., Philip G. Danufsky, M.D., Harold Frederiksen, M.D., Thomas Grayston, M.D., Robert T. Haberman, D.V.M., Martin Hicklin, M.D., Munroe Holmes, D.V.M., Ernest Kane, M.D., Robert Kerns, D.V.M., Arthur Lewis, D.V.M., Ladd Loomis, D.V.M., Robert Menges, D.V.M., Garth Myers, M.D., Cecil Reinstein, M.D., Henry R. Shinefield, M.D., Wm. H. Stewart, M.D., James Strain, M.D.

They are also indebted to Allan Gittlesohn, Public Health Analyst, Bureau of Records and Statistics, California State Department of Public Health, for compilations, tabulations and graphs of the data collected.

REFERENCES

1. Dean, B. H., and Meiklejohn, G.: Unpublished data.

2. Halverson, W. L., Longshore, W. A., Jr., and Peters, R. F.: The 1952 encephalitis outbreak in California, Public Health Reports, 68:369-377, April 1953.

3. Kokernot, R. H., Shinefield, H. R., and Longshore, W. A., Jr.: Problems in differential diagnosis of the acute disease (encephalitis), Calif. Med., 79:73-76, Aug. 1953.

4. Lennette, E. H., and Longshore, W. A., Jr.: Western equine and St. Louis encephalitis in man, California, 1945-1950, Calif. Med., 75:189-195, Sept. 1951.

5. Lennette, E. H., Nyberg, M., Barghausen, D., Chin, R., Fujimoto, F., and Itatani, M.: The 1952 outbreak of encephalitis in California—Laboratory methods for etiologic diagnosis, Calif. Med., 79:78-83, Aug. 1953.

6. Longshore, W. A., Jr.: Unpublished data.

7. Reeves, W. C.: Personal communication.

8. Stead, F. M., and Peters, R. F.: The 1952 outbreak of encephalitis in California—Vector control aspects, Calif. Med., 79:91-93, Aug. 1953.

The 1952 Outbreak of Encephalitis in California

Vector Control Aspects

FRANK M. STEAD, M.S.P.H.(E), *San Francisco*, and RICHARD F. PETERS, B.S., *Berkeley*

• The emergency vector control measures used during the summer of 1952 were designed to supplement the normal mosquito control programs of mosquito abatement districts. The emergency measures were aimed at destruction of adult vector mosquitoes in populated areas as contrasted to normal programs which consist of elimination of breeding places or destruction of the aquatic stages of mosquitoes.

Experience during 1952 clearly demonstrated the limitations of present techniques for coping with adult mosquitoes and pointed up the need for better understanding of the factors controlling survival of Culex tarsalis over the winter months, as well as the need for better methods of measuring the prospect of a large number of infected vector mosquitoes early enough in the year to permit the establishment of preventive rather than palliative measures.

TO FULLY APPRECIATE the task of planning and carrying out emergency vector control measures to cope with the 1952 outbreak of viral encephalitis in California, one must consider the actual situation which confronted us and the choices that had to be made quickly without benefit of previous similar experience.

Concerning the disease, these four simple things were known with reasonable certainty: (1) It is caused by one or both of two known viruses. (2) The source or reservoir of the virus in nature is birds. (3) The disease is transmitted to man by a mosquito; and the species Culex tarsalis is the predominant vector in California. (4) Vector control was the only possible method of attack in 1952 since measures against the reservoir were not conceivable and no vaccine was available for use in humans on a widespread basis.

It was therefore inescapably clear that the only measures that could be taken to reduce the number of cases of the disease were measures which would reduce the contact between susceptible human beings and infected Culex tarsalis mosquitoes.

The great inland Central Valley of California, extending from Kern County to Shasta County and lying between the Coast Range and the Sierra Nevada, has a floor of some 25,000 square miles in extent. Something over half of this vast expanse of agricultural land is served on a year-round basis by local mosquito abatement programs. Since 1946 a $400,000-per-year subvention fund to assist local mosquito abatement programs in areas of mosquito-borne disease threat has been administered by the State of California in a manner to focus mosquito control attention in the Central Valley on efficient control of disease-carrying mosquitoes.

Consequently, in July 1952 there was already in operation a large scale mosquito control program consciously directed to the control of the very species that had to be dealt with to curb the outbreak of encephalitis; and over two-thirds of the population resident in the Central Valley lived within the boundaries of such mosquito abatement districts.

CAUSE OF INCREASE IN VECTORS

Why, then, were cases of encephalitis occurring in alarming numbers, especially among people living in areas that had efficient mosquito control programs? There were two principal reasons: The first was that the tremendous expansion of mosquito breeding areas in the years following World War II as a result of the importation of water into the previously dry areas of the Central Valley, and the putting of hundreds of thousands of acres of previously high and dry land into crops requiring intensive and repetitive irrigation, increased the mosquito production potential of the Central Valley so many fold that only the use of the "miracle" insecticides, such as DDT, enabled mosquito control to keep pace without fantastic costs. Progressively over a period of three years DDT-resistant mosquitoes developed, so that in 1952 the previous effectiveness of mosquito control by chemical treatment was be-

From the State Department of Public Health. Chief, Division of Environmental Sanitation (Stead), and Chief, Bureau of Vector Control (Peters).

Part of the Symposium on Encephalitis presented by the Section on Public Health at the 82nd Annual Session of the California Medical Association, Los Angeles, May 24 to 28, 1953.

ginning to crumble. The second reason was that heavy rainfall and snow pack, coupled with an unusually warm winter, resulted early in the spring of 1952 in a greatly increased area of ideal mosquito breeding places in river bottoms and overflow areas. These places quickly became seeded with eggs by the unusually large number of adult Culex tarsalis surviving the warm winter.

The mosquitoes had "never had it so good" and they invaded the agricultural and urban areas in countless numbers. The problem, therefore, seemed to be to cope with a situation in which the normal preventive programs had broken down and the cities and towns were being invaded by hordes of infected adult mosquitoes, each capable of living at least thirty days unless extremely high temperatures intervened to reduce their numbers. This in short was the situation the latter part of July when, if experience in previous years was a guide, the peak of the outbreak should be near.

ATTACK ON ADULT MOSQUITOES

It seemed obvious, then, that if an emergency program were to have any real effect in halting an outbreak that was already a fact, it would be necessary to forsake the basic axiom of prevention and kill adult mosquitoes before they killed us. Any other approach to the problem would be too slow. The next fact that became crystal clear was that it was useless to consider an emergency field program that would be spread over 25,000 square miles, even though many of the inhabitants of the Central Valley lived in isolated houses on farms. Sheer realism dictated that the only chance of doing anything to change the course of the outbreak lay in destroying the mosquitoes already in the some 300 cities and towns of the Central Valley and establishing a defense against invasion of these urban areas by new mosquitoes from the outlying rural areas. Out of this realization came the broad outline of the major features of the much publicized "Operation Culex Tarsalis." The plan was for a three-pronged attack:

1. Aerosol fogging of the entire areas of the cities and towns in the valley from one to three times per week during the months of August and September;

2. Establishment of a perimeter barrier at least one-fourth mile wide around the periphery of each city and town by spraying all appropriate outdoor surfaces, such as buildings, other structures, and vegetation;

3. Intensive larvicidal treatment of all mosquito breeding areas within or immediately adjacent to the cities and towns.

The fogging was to kill adult mosquitoes that penetrated the defenses; the perimeter barrier was to leave a lethal residue of insecticide on all surfaces upon which invading mosquitoes might light (it being assumed that a mosquito would probably light at least once in one-fourth mile of travel if attractive resting places were available); and the larvicidal work was intended to prevent the breeding of new mosquitoes within the defenses or closely adjacent to them.

The nature of the program having been determined, the next question was: Who will do it? It was decided that within the mosquito abatement districts the regular mosquito control agency should carry out the emergency operation in addition to its normal program of prevention, and that in areas outside mosquito abatement districts the state could provide the supplies, special equipment and technical supervision if cities and counties supplied vehicles and labor.

Technical supervision entailed not only direction of insecticidal field operations but evaluation of their timing and effectiveness by biological observations. It was apparent that the full technical vector control staff of the State Health Department would be inadequate for the job, and a request to the U. S. Public Health Service resulted in a sizable augmentation of the technical staff with engineers and entomologists. Cities, counties, local health departments and mosquito abatement districts responded to appeals for help in carrying out the program and it is estimated that during the months of August and September more than 200 men were working full time, seven days a week, on Operation Culex Tarsalis.

The cost of special equipment and supplies for the entire operation, together with other necessary expenses, was estimated at $250,000; and this amount was made available from the state's emergency fund, about two-thirds of it being spent inside mosquito abatement districts and the remainder outside. Without question, local contributions to the emergency program exceeded this figure.

NEEDS FOR THE FUTURE

Taken all in all, Operation Culex Tarsalis stands out as an unusual cooperative statewide joining of forces to meet a dangerous enemy. It seems probable that the emergency measures prevented many cases of western equine encephalitis that would otherwise have occurred; and probable also that the number of cases of St. Louis encephalitis, which usually develop several weeks later than those of the western equine disease, would have been considerably greater had the control measures not been effected. However, in review of the experiences of 1952 with future outbreaks in mind, the conclusion

is inescapable that the normal preventive mosquito control program in the Central Valley is incapable of protecting the population in a year of unusual environmental conditions, and it must also be recognized that the emergency vector control measures employed in 1952 were palliative only.

The first great shortcoming that stands out in a review of the record of 1952 is the disastrously late start of the emergency program. This was due not to a lack of information on occurrence of cases of encephalitis in humans, but to lack of reliable current records, throughout the year, as to the numbers of adult Culex tarsalis mosquitoes in every part of the Central Valley and the proportion of them that carried the viruses of encephalitis.

A second major defect was the disappointing results in many instances with the use of aerosol fogging techniques. Heretofore in California, fogging with insecticide has been employed principally to cope with invasions of pest mosquitoes of the Aedes species. During the emergency program fogging still was effective against Aedes mosquitoes, but only partially effective against Culex.

The two great needs for effective control of mosquito-borne encephalitis in California in future years, therefore, are improved mosquito control techniques, both preventive and emergency, and improved information. To meet these needs, plans have already been drawn for intensive ecologic studies of Culex tarsalis, for investigation of the toxicity of all the current insecticides to mosquitoes in all stages from egg to adult, for development of equipment and techniques for the application of insecticides, for modifications of agricultural practices to minimize mosquito breeding, and finally for the development of an objective method of measuring the density of occurrence of mosquitoes (by species) through an established valley-wide network of observation points. Such a program of determining the numbers of mosquitoes by use of standard equipment to sample mosquitoes, both flying and resting, would be carried on the year around; and during the months from February to October, collected Culex tarsalis mosquitoes would be sealed in pools of fifty each and examined for viruses.

760 Market Street.

The 1952 Outbreak of Encephalitis in California

Long Term Neurologic and Psychiatric Studies of Sequelae

KNOX H. FINLEY, M.D., *San Francisco, and*
W. MAX CHAPMAN, M.D., M.P.H., *Berkeley*

• For fuller understanding of the nature of infectious encephalitis, continuing study must be made of patients with regard to possible neurological sequelae or aberrations in behavior.

The large outbreak of encephalitis in California in 1952 having offered opportunity for follow-up observation of a large series of patients, many of them children who had convulsions during the acute phase of the disease, pilot studies already have been started and funds are being sought for extending the scope of the investigation over a period of years.

In early observations of patients included in the pilot study, changes in emotional and behavior patterns were noted in some instances. Thus far, with the exception of two infants who had recurrence of convulsions, patients who recovered apparently free of residual effects have remained so.

Further neurological and psychiatric investigation should be carried out.

THE LARGEST EPIDEMIC of infectious encephalitis in California's history occurred in the summer of 1952. Seven hundred ninety-two cases were reported from June through October. In 414 cases etiologic diagnosis was made by serologic tests done at the Viral and Rickettsial Disease Laboratory of the State Department of Public Health. Laboratory results were inconclusive in 108 other cases, while in 198 clinically reported cases of encephalitis the results of laboratory tests were negative.

This group of cases presents an opportunity for follow-up study which is superior to anything previously available. Furthermore, since approximately one-fourth of these cases were in infants under one year, and one-half in children of ten years and under, the need for follow-up study is obvious.

Although the clinical diagnosis of encephalitis as a neurological syndrome has been correctly made in the past, until recent years the specific etiologic agents were not known (for example, the great group of Von Economo's encephalitides, or sleeping sickness). During the past 20 years the viruses causing some of the clinically recognized acute neurological infectious disorders have been identified.[7, 9, 10, 11]

Now, for the first time, a large number of persons who had infectious encephalitis, confirmed both clinically and by the laboratory, can be followed from convalescence through ensuing years. Continuous observation of them will provide a basis for sound conclusions relative to the frequency and severity of neurological and psychiatric residual effects. Furthermore, it will be determined whether neurological complications occur after a period of apparent recovery. It has been the authors' impression that there are residual effects in fewer than 5 per cent of persons who have had St. Louis or western equine encephalitis. This is in contrast to the more severe manifestations in eastern equine and Japanese B encephalitis. This study will remove the uncertainty associated with these impressions.

The scope of the study includes several types of investigation, some of which are best done by the facilities of the state and local health departments; the clinical phase of the follow-up, however, lends itself very well to the resources of a medical school. A cooperative program, therefore, is being planned jointly by the state and local health departments and the Stanford University School of Medicine. The details of such a plan take time to work out. Recognizing that important data would be lost through delay, the State Department of Public Health set up a pilot study to operate for six months (January-June, 1953) while plans were being made for a long term study. The program was set up in San Joaquin County where 57 laboratory-confirmed and inconclusive cases occurred during the 1952 summer epidemic. The pilot study is a coordinated activity of the State Department of Public Health, San Joaquin

From the Division of Neuropsychiatry, Department of Medicine, Stanford University School of Medicine (Finley), and the Bureau of Acute Communicable Diseases, California State Department of Public Health (Chapman).

Part of the Symposium on Encephalitis presented by the Section on Public Health at the 82nd Annual Session of the California Medical Association, Los Angeles, May 24 to 28, 1953.

County District Health Department, and the division of neuropsychiatry, department of medicine of the Stanford School of Medicine, with the assistance of the electroencephalographic laboratory facilities of the Stockton State Hospital.

Before setting up clinics for this follow-up study, the county health officer discussed the plan with the San Joaquin County Medical Society and received its approval. A plan for sending follow-up progress notes to the physician who treated the patient was under consideration from the beginning and is now in operation. It was decided that during the first year the patients should be checked every three months. Depending upon the results of the pilot study, patients will be followed once or twice a year for the next two or three years, and possibly less often as indicated for following years.

Encouraging factors in the early part of the study were the interest of physicians and patients in San Joaquin County and the requests from other counties that they be included in the initial pilot study. The San Joaquin pilot study area, together with the counties from which requests have been received, actually includes therefore the major portion of the epidemic areas in the Central Valley of the state. In light of the requests, it was felt that insofar as possible the pilot study should be extended to include the additional counties. Therefore, 14 clinics were held, two each in Kern, Fresno, Stanislaus and Sacramento, and others in Tulare, Kings, Merced and Contra Costa counties. Because of this interest, additional observations have been made by the county health departments in Butte, Sutter, Yolo and Yuba counties.

OBSERVATIONS IN PILOT STUDY

In the pilot study, 441 follow-up examinations were made on approximately 300 patients. Electroencephalograms have been obtained in 33 cases. They were made in several different laboratories and have not yet been analyzed.

A common unsolicited comment by husband or wife may be phrased in this manner: "Since the illness, he has acted like a different person—fussy with the children, irritable to me, and generally rather restless." With reference to some children, parents have voluntarily stated that they had noted a difference in behavior following the illness. In one case the child had become pugnacious toward his associates. He was restless, was not sleeping or eating as well as formerly, and had emotional outbursts characterized by temper tantrums and crying for no apparent reason.

In general it was noted that emotional and behavior changes may occur with or without detectable neurological damage.

Another complication of interest was residual headache that was a complaint in many cases. In some instances it was a major complaint for several months following the acute febrile phase of the illness, and a common reply by a patient when asked how he felt was, "If only I could get rid of this terrific headache, I think I'd feel all right."

These observations are in agreement with those of others who have reported on postencephalitic behavior.[2, 3, 4, 6, 8]

It is too early to give a completed survey of the clinical results of studies to date except to say that at present all patients who recovered free of residual effects have remained so, except for two infants who had a recurrence of convulsions.

As a result of the pilot study, the need for a control group or groups is recognized. For example, it might be said that the unusual behavior in children returning home from the hospital is due to the excessive amount of attention and care they received while there. It has been suggested, therefore, that a similar group of patients who had non-paralytic poliomyelitis and who likewise received hospital care but did not have encephalitis, be selected for comparison of behavior following return to their homes. Another control would be a follow-up study of the siblings of patients to check their medical histories against those of the patients who had encephalitis.

Since it is recognized that in encephalitis such as, for example, Von Economo's, neurological or psychiatric complications may develop months or years after the acute phase of the disease, it is important that this pilot study be followed through on a long-term basis, over a period of from 10 to 15 years. For example, the study of patients who had convulsions warrants long term observation. Almost 80 per cent of patients under one year of age in the group under study and 60 per cent of the children under five years of age had one or more convulsions during the acute phase of encephalitis. The association of convulsions with high fever has long been recognized by pediatricians but the exact etiologic relationship is usually not known. Now available for study, however, is a group of infants and children who have had one to several convulsions during the initial phase of an illness in which there is specific knowledge of the organism and of its action on the central nervous system. It is also recognized by pediatricians and neurologists that sometimes a patient who has a convulsion with a fever in infancy or early childhood develops an epileptic disorder later, often during the adolescent years. It is therefore most important that these children who have had one or more convulsions during the acute phase of etiologically diagnosed encephalitis be kept under observation at least through adolescence.

The importance of follow-up study from the psychiatric standpoint was recognized by Fulton and Burton[5] in a follow-up study of several patients who had had western equine encephalitis during a large epidemic in Saskatchewan, Canada. They found that after a few years several children and adults developed personality changes that necessitated psychiatric institutional care. Recognizing the possibility of relationship, authorities of the Saskatchewan mental hospitals now have tests for encephalitis antibodies carried out on all patients entering the institutions.

From these observations, the importance of a careful immunological and clinical follow-up study of established cases of St. Louis and western equine encephalomyelitis occurring in the Central Valley of the state becomes apparent. In view of the unusual opportunities afforded and the obvious clinical reasons for studying this large number of proven cases, a request has been made to the National Institutes of Health for a long-term grant to make possible continuous study of these cases. If the grant is received, the present preliminary follow-up study will be extended over a period of from 10 to 15 years. It is also planned to include in this study a certain number of proven cases from earlier years as well as to add future proven cases and to make additional pathological studies insofar as funds permit. From this work, more precise knowledge will become available relative to the after-effects of the infectious encephalitides which are endemic in the Central Valley of California.

450 Sutter Street.

REFERENCES

1. Ayres, J. C., and Feemster, R. F.: The sequelae of eastern equine encephalomyelitis, N.E.J.M., 240:960-962, 1949.

2. Bond, E. D., and Appel, K. E.: The Treatment of Behavior Disorders Following Encephalitis, The Commonwealth Fund, New York, 1931.

3. Bond, E. D., and Smith, L. H.: Postencephalitis behavior disorders: A ten-year review of the Franklin School, Amer. J. Psychiat., 92:17, 1935.

4. Ford, F. R.: Diseases of the Nervous System in Infancy, Childhood and Adolescence, 1937.

5. Fulton, J. S., and Burton, A. N.: Human encephalitis in Saskatchewan caused by the virus of western equine encephalomyelitis, Canad. J. Pub. Health, 43:212-220, 1952.

6. Heersema, P.: Prognosis in post-encephalitic disorders, Amer. J. Dis. Child., 60:783, 1940.

7. Howitt, B. F.: Recovery of the virus of equine encephalitis from the brain of a child, Science, 88:455, Nov. 11, 1938.

8. Kennedy, R. L. J.: Prognosis of sequelae of epidemic encephalitis in children, Amer. J. Dis. Child., 28:158, 1934.

9. Lennette, E. M.: Isolation of St. Louis encephalitis virus from a fatal human case in California, Proc. Soc. Exp. Biol. and Med., 61:206, March 1946.

10. Meyer, K. F., Haring, C. M., and Howitt, B. F.: The etiology of epizootic encephalomyelitis of horses in the San Joaquin Valley, Science, 74:227, Aug. 28, 1931.

11. Muckenfuss, R. S., Armstrong, C., and McCordock, H. A.: Encephalitis—studies on experimental transmission, Public Health Report, 48:1341, Nov. 3, 1933.

12. Neal, J. B.: Encephalitis—A Clinical Study, Grune & Stratton, 1942.

Coccidioidomycosis in San Fernando Valley

Report of a Study Carried Out in 1951-1952

H. H. COWPER, M.D., and J. EMMETT, M.D., Los Angeles

• *Four cases of benign pulmonary coccidioidomycosis occurred during May 1951 among some 35 teenage students at a boarding school and farm for boys that occupies 30 acres in the northwestern section of the San Fernando Valley within the City of Los Angeles.*

Epidemiological and serological study of the patients yielded evidence that exposure had occurred on the farm or nearby.

Correlation of results of skin testing for sensitivity to coccidioidin among students over the subsequent months and of serologic studies in cases in which there was positive reaction to skin tests indicated exposure to coccidioides during the time the subjects were in residence at the school. In addition, two boys had conversion from negative to positive reaction to coccidioidin while they were in residence.

IN MAY 1951, four cases of acute pulmonary coccidioidomycosis occurred among a group of some 35 teenage boys resident in a facility in the Chatsworth area of San Fernando Valley. Symptoms at the onset of illness included headache, malaise, cough, pain in the chest, fever and, in two cases, a rash diagnosed as erythema nodosum.

In all cases abnormalities were observed in x-ray films of the chest. They were described, respectively, as bilateral hilar pneumonitis; left hilar adenopathy, calcified, with a 2 cm. cavity in the second left interspace; right hilar adenopathy with hazy area right upper lobe; and rounded, hazy density right base suggestive of pneumonia.

The boys became ill May 10, 23, 25 and 29 respectively. Skin tests with coccidioidin in 1:100 dilution were done in three cases within two weeks of the onset and in one case two months after onset. There was positive reaction in all cases. Results of complement fixation tests for coccidioidal infection were positive in the one case in which they were done, three months after onset. Precipitin tests in the same case were negative.

Coccidioides immitis was recovered from gastric washings in one case. This and the clinical course and findings, roentgenographic observations and positive reaction to skin tests establish the diagnosis with reasonable certainty.

The four boys who had the disease had been in continuous residence at the school for periods varying from four to eight months at the time of onset. None had made recent trips outside the area. The incubation period of pulmonary coccidioidomycosis is usually nine to eleven days. All the boys had had virtually constant exposure to dust and soil in an area in which cases of coccidioidal infection have been reported for years. It was not possible to identify any single, common exposure even in the three cases in which onset occurred within the span of a few days.

In July, 19 of the other resident boys were given skin tests and five had positive reaction. Complement fixation and precipitin tests were done on specimens of blood from those with positive reaction. In two cases there were precipitins only, in one both precipitins and complement fixing antibodies, in one only complement fixing antibodies, and in one neither. Since precipitins precede complement fixing antibodies in the blood and are shorter lived[1] three of the boys with positive reaction apparently had been recently exposed to *Coccidioides immitis* and had infection without clinical symptoms while the other two apparently had had exposure at a time more or less remote. The five boys with positive reaction but no clinical symptoms had been in continuous residence at the school for from two to eight months prior to testing. In September, seven more boys (old residents and new arrivals) were given skin tests and three of them, old residents who had been missed in the previous tests in July, had positive reaction. They had been in continuous residence at the school for eight, nine and twelve months. Complement-fixation and precipitin tests were done on serum from these three boys. None had precipitins, two had complement-fixation antibodies and one had neither. These results indicate that exposure had been more than three months previously.

Dr. Cowper was formerly director of Communicable Disease Control, Los Angeles City Health Department. Dr. Emmett was formerly with the Communicable Disease Center, Public Health Service, Federal Security Agency, assigned to the Los Angeles City Health Department, 1951-1952.

In addition, seven boys who had reacted negatively to the coccidioidin skin test in July were retested in September. One had positive reaction, and precipitins were present in the blood. There were no clinical symptoms. As the boy had not left the area between the test in July and that in September, exposure in the area in question was clearly indicated.

Two subjects who in July had had positive reaction to skin tests, and precipitins but no complement-fixation antibodies in the blood, were retested in October. At that time the serum of one revealed complement-fixation antibodies only, which had developed in the interval and persisted, while the precipitins had disappeared. In the serum of the other there were neither precipitins nor complement-fixation antibodies.

In subsequent months boys entering the school were given skin tests before they were enrolled. None had positive reaction at that time. In May 1952, the 35 boys then in resident at the facility were retested and on this occasion one who two and a half months previously had had no reaction had positive reaction, which confirmed the endemicity of coccidioides in the area. One other boy with positive reaction in May 1952 had been in residence at the school continuously for the preceding 18 months. Five members of the staff were also given skin tests at this time and one had positive reaction. He had been born in the San Fernando Valley and had lived there all his life with the exception of four years spent in Oregon.

CONCLUSIONS

Coccidioides immitis is endemic in the Chatsworth area of the San Fernando Valley.

In the cases here described the patients were exposed and infected while participating in various outdoor play and farming activities in the area.

116 Temple Street.

ACKNOWLEDGMENT

Grateful acknowledgment is made to Dr. C. E. Smith, Dean, School of Public Health, University of California, for his helpful suggestions and performance of serological tests through facilities provided by the Commission on Acute Respiratory Diseases of the Armed Forces Epidemiological Board; to the staffs of Rancho San Antonio and the Juvenile Hall for their pleasant cooperation; and to Miss R. Sem, R.N., of the Los Angeles City Health Department for her invaluable assistance with the skin testing.

REFERENCES

1. Smith, C. E., Saito, M. T., Beard, R. R., Kepp, R. M., Clark, R. W., and Eddie, B. U.: Serological tests in the diagnosis and prognosis of coccidioidomycosis, Am. J. Hyg., 52:1, July 1950.

Urinary Tract Infections

Problems in Medical Management

ERNEST JAWETZ, M.D., Ph.D., San Francisco

• The lesion principally responsible for chronic, or recurrent, urinary tract infection is a focus in the interstitial tissue of the kidney. Most cursory antimicrobial therapy suppresses the manifestations of lower urinary tract involvement but does not eradicate the renal focus. In order to cure rather than merely suppress the infection, it is imperative that, as early as possible, steps be taken to isolate and identify the etiologic microorganism and to determine its sensitivity to antimicrobial agents. Based on this information sufficient amounts of drug should be given for an adequate period (probably at least two weeks) to eradicate the infection within the renal tissue. Such a program would tend to reduce the number of cases in which irreversible renal failure develops from chronic pyelonephritis.

INFECTIONS of the urinary tract are second in frequency only to upper respiratory tract infections, and often more severe. In a series of 3,000 unselected autopsies active "septic infection" of the urinary tract was noted in 4.8 per cent.[12] Before attempting to discuss the management of these disorders it may be desirable to outline their natural history. It had long been suspected that some connection existed between the acute, brief episodes of manifest urinary tract infection and the ultimate development of renal failure. The long term studies of individual patients by Longcope and Winkewerder[9] suggested that often a process of inflammation smouldering below the levels of manifest symptoms connected the episodes of clinically evident pyelonephritis and resulted in progressive scarring and fibrosis of renal tissue. That such a progressive course is by no means inevitable is indicated by the finding[11] of the scars of healed pyelonephritis in nearly 14 per cent of 1,000 consecutive autopsies at the Boston City Hospital. Pyelonephritis thus often heals spontaneously. However, occasionally it may be a very malignant disease with rapid progression toward renal failure, as in papillary necrosis occurring in nearly one fifth of diabetic patients with pyelonephritis.[10]

The hypothetical life history of a female with urinary tract infection (Chart 1) will serve as illustration. In early childhood there occurred a febrile episode recognizable as acute pyelonephritis, perhaps associated with some minor anatomical anomaly of the urinary tract. Or possibly even the initial episode was mild and not associated with clear-cut symptoms referable to the urinary tract. Subsequently the process was quiescent or only minor flare-ups occurred during adolescence. Shortly after marriage the patient had an attack of "honeymoon pyelitis." During pregnancy "pyelitis" developed in the second or third trimester. There was no toxemia and a normal delivery was followed by a period of quiescence and apparent health. Both in childhood and in adult life the infection might spontaneously heal completely. (More frequently, however, there are continuing attacks of pain in the flanks, intermittent pyuria, dysuria and urinary frequency with little fever or other systemic manifestation. During symptom-free periods bacteria may often be detected in the urine.) Up to this time the kidney function was quite unimpaired. Then nitrogen retention, proteinuria, and perhaps an associated rise in blood pressure developed. Subsequently, the progression of renal failure was exceedingly rapid, or perhaps it developed slowly over many years.

Looking at urinary tract infection as a long-term problem and not as a series of brief, unconnected episodes, it becomes clear that the basic, important lesion is not an infection of the urine, or of the duct

LIFE CHART OF A FEMALE PATIENT WITH URINARY TRACT INFECTION

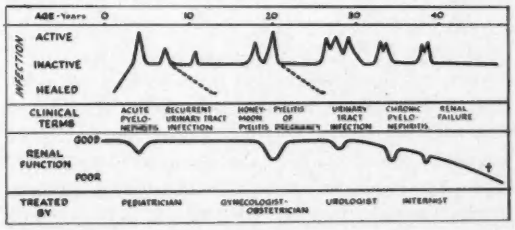


CHART 1

From the Divisions of Microbiology, Medicine and Pediatrics, University of California School of Medicine, San Francisco.

Presented before the Section on Pediatrics, at the 82nd Meeting of the California Medical Association, May 24-28, 1953.

Based on a cooperative study with Drs. James Hopper, Jr., and Frank Hinman, Jr., and supported in part by a grant-in-aid from Burroughs Wellcome & Co., Tuckahoe, N. Y. Dr. Donald R. Smith gave valuable advice.

system from glomerulus to bladder, but infection of the interstitial tissue of the kidney.[2, 9] Regardless of the route (whether hematogenous, lymphogenous, or urogenous) by which the infecting bacteria reach the kidney, it is the chronic inflammation within the parenchyma with destruction and fibrosis of nephrons that determines chronicity, resistance to treatment, and ultimate outcome. The management of urinary tract infection and its problems must be considered from this point of view. It was recently stressed by Birchall[1] that one of the difficulties in over-all management is the discontinuity of attack, each episode being treated as an isolated event by a different physician (pediatrician, gynecologist, urologist, internist). For optimal handling of the patient a different, long-term approach is necessary.

To cover all aspects of the disease the management of urinary tract infection falls properly into three categories: (1) Correction of structural abnormality of the tract. (2) Treatment of the infective process. (3) Palliative management of renal failure and associated disturbances. The first is in the province of the urologist; investigation and correction are carried out by specialized methods. The third, the treatment of renal insufficiency, hypertension and other consequent conditions, requires careful attention to detailed management of fluids, electrolytes, diet and other such factors. Expert management along these lines will often keep a patient alive to receive antibiotic therapy. This presentation is concerned with the second of the three categories of management mentioned above, treatment of the infectious process, for by optimal treatment organic damage to the kidney may be prevented.

A planned attack upon the infective process includes a specific etiologic diagnosis, selection of appropriate antimicrobial agents, administration of them in adequate doses for a sufficient time, and prolonged follow-up to establish cure with certainty. It is proposed to consider each of these elements in their logical sequence. Some technical detail will have to be included since, quite commonly, minor "unimportant" features are omitted, contributing to therapeutic failure.

ETIOLOGIC DIAGNOSIS

The key to etiologic diagnosis is a careful examination of the urine. Urine specimens must be collected, before chemotherapy is started, by methods suitable to exclude contamination from the outside (catheterization in females; clean, voided specimens in males), and must be examined promptly lest bacteria either die or multiply. Complete bacteriological examination includes the following procedures:

1. Examination of a stained smear of urine. (Ordinarily bacteria will be noted only if the number exceeds 10,000 per milliliter.)

2. Qualitative culture to isolate the different kinds of bacteria present.

3. Quantitative culture to estimate the number of bacteria in fresh urine. This is essential because the voided urine of normal persons may contain a few bacteria, perhaps up to 500 per milliliter. These organisms originate in the normal urethral flora or in occasional lymphatic transport from other viscera to the lower urinary tract. Their presence does not ordinarily denote disease. Larger numbers of bacteria, in excess of 1,000 per milliliter, even in the absence of pus cells, are indicative of urinary tract infection.

4. Special studies, when indicated, to detect anaerobic bacteria, tubercle bacilli, fungi, or pleuropneumonia-like organisms.

THERAPEUTIC AGENTS

The principal reason for isolating the etiologic microorganisms is not the academic one of specific diagnosis for its own sake, but the urgent need to determine the antimicrobial drug most likely to be effective against the particular microorganism. What with the large scale use and misuse of antibiotics, many patients now harbor bacteria which are resistant to one or several drugs. The rapid, qualitative "disc" method of antibiotic sensitivity testing, in spite of many inadequacies, often gives a valuable lead as to what drugs are likely to inhibit the infecting microorganisms, and, of equal value, what drugs should not be used because the organisms appear to be resistant to them. While this, admittedly, is only a partial answer to the problem, such an answer can be obtained rapidly and cheaply. If a proper urine specimen is submitted to the laboratory in the afternoon, the physician can be informed the next morning as to the kinds and the number of bacteria present and the drugs to which they are resistant or sensitive. With good collaboration between physician and laboratory these results can give valuable guidance to therapy.

Most antimicrobial drugs are excreted largely through the kidneys and concentrated in the proximal convoluted tubules. Consequently the drug concentration in the urine tends to be several times that present in body fluids, blood, or tissues. For this reason it has become customary to use small, so-called "urinary doses" of most antimicrobial agents which result in urinary concentrations sufficient to inhibit most infecting microorganisms. Thus 0.5 gm. of a sulfonamide taken four times daily results in a concentration of approximately 50 mg. of the drug per 100 cc. of urine, but would obviously not

be an adequate amount to produce systemic tissue levels of the drug. If such "urinary doses" of antimicrobial drugs are taken for a few days the urine is usually "sterilized" quite promptly, and the symptoms, particularly of lower urinary tract involvement, subside rapidly. Cultures taken during therapy and immediately thereafter are frequently negative. This may lead to the belief, often unwarranted, that the patient has been "cured."

It has been said already that in pyelonephritis there is primarily infection in the interstitial tissues of the kidney, and that the involvement of the urinary passages is often secondary. The condition of the urine may be only a manifestation of the neighborhood involvement of renal tissue and inflammation of the lower tract. On the other hand, the urine may be sterile and contain no pus cells while there is active and progressive infection and inflammation in the renal parenchyma. Logically, therefore, treatment should not be limited to sterilization of the urine, which can be readily accomplished, but should be directed to eradication of the renal infection. From this standpoint the use of "urinary dosage" of antimicrobial agents, and of "urinary antiseptics," such as methenamine, which function only in an environment of acid urine, seems quite perfunctory. Such therapy provides symptomatic relief, without attacking the source of the trouble. This situation in pyelonephritis could be compared to that well-recognized in bacterial endocarditis.[4] If a patient with endocarditis is treated with small doses of a drug that can inhibit the infecting organism, the symptoms of infection (fever, embolic phenomena, fatigue) may subside and no organisms grow on a culture of blood. However, soon after such treatment is discontinued, relapse occurs, because the focus of active infection within the vegetation on the heart valve has not been eradicated. Such patients are cured only if a drug known to kill (and not merely inhibit) the infecting organism is given in adequate dosage for a sufficient length of time to penetrate the vegetation, eradicate most viable organisms and permit solid fibrosis to encapsulate the remaining few central bacteria so that they will be unable to proliferate again when chemotherapy is discontinued.

It would seem logical to apply similar principles in the treatment of urinary tract infection when renal involvement is evident. Following isolation of the infecting microorganism from the urine, it should be subjected to antibiotic sensitivity tests that measure not only the inhibitory but also the killing capacity of the drug.[4, 6, 8] Then, using drugs, singly or in combination, that are lethal to the infecting bacteria in the test tube, "systemic" rather than "urinary" doses should be given — that is, amounts sufficient to saturate tissues with drug levels capable of eradicating the bacteria. This drug regimen must be continued long enough to permit sterilization of tissues, probably for more than two weeks. Subsequently cultures should be obtained for at least three months, to make certain infection does not recur. It is probable that with such a course of treatment generally carried out, the rate of permanent cure would be greatly increased and that the number of cases in which disease progressed into renal failure owing to chronic pyelonephritis would be diminished.

However, this ideal — possibly idealistic — approach to treatment is not without flaws, which pertain to the properties of antimicrobial drugs and to characteristics of chronic pyelonephritis.

Most cases of pyelonephritis are associated with Gram-negative bacteria. The principal drugs active against such organisms, like sulfonamides, aureomycin, chloramphenicol, or terramycin, are inhibitory rather than bactericidal. They often "sterilize" the urine promptly, but probably do not eradicate foci of infection in the interstitial tissue of the kidney, just as they do not cure bacterial endocarditis.[4] Streptomycin is bactericidal but drug-resistant forms emerge so quickly that this drug cannot be usefully employed alone for more than four days in bacterial infections, a time too short to permit eradication of an interstitial focus. Combinations of drugs may occasionally be used for this purpose but selecting them in the laboratory still remains a laborious procedure, and an indiscriminate mixture of drugs is likely to be ineffective. Available information about antibiotic combinations has been summarized elsewhere.[6]

Among other drugs, polymyxin B would appear to offer some hope. This agent is highly bactericidal for many Gram-negative bacteria,[7] including many resistant to other drugs. Recent studies indicate[3] that in persons with good renal function doses up to 2 mg. per kilogram of body weight per day for 14 days are tolerated without significant evidence of nephrotoxicity. There are, however, unpleasant side actions (local pain at injection site, neurotoxic effects) which make more prolonged use difficult to tolerate. In selected cases of acute pyelonephritis in children, polymyxin B resulted in complete eradication of infection.[5, 13] When adults with known long-standing pyelonephritis, but good renal function, were treated with polymyxin B for two weeks in doses of 1.5 to 2.2 mg. per kilogram per day, cultures of the urine promptly became negative for bacterial growth and remained so for from one to six weeks after treatment. However, in many cases the original bacteria reappeared in the urine eventually. This suggests strongly that the fibrosing in-

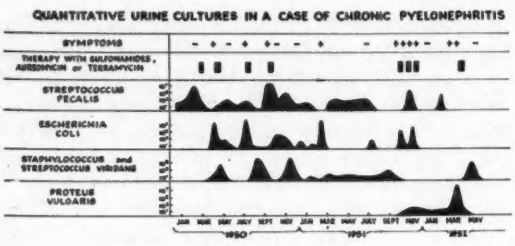


CHART 2

fectious focus in the renal tissue is not readily accessible to drugs and that treatment would have to be much more prolonged than seemed feasible with polymyxin B.[3]

It is a common experience among those who treat many patients with chronic urinary tract infection to observe the disappearance of the prevalent bacterial species under treatment with one drug, and its replacement with another species, usually resistant to the agent being used. The origin of these "superinfecting" organisms is not known, but it seems that they usually appear when a prevalent bacterial population is suppressed by antimicrobial therapy. However, that event merely seems to increase the opportunity for multiplication, and perhaps establishment of a different bacterial species. When quantitative studies of the growth of organisms on cultures of the urine of persons with long-standing urinary tract infection are carried out, spontaneous changes in flora are sometimes observed as shown in the detailed bacteriological study summarized in Chart 2. While it seems definite that the patient initially harbored an enterococcus infection in the kidney parenchyma, other organisms appeared at times in the urine, and on certain occasions enterococci could not be found, but only the "superinfecting" bacteria descended from the kidneys.

It might even be conjectured that some abnormality of lymphatic connection, or of urinary flow, might predispose such a person to continuous seeding of the kidneys with enteric organisms; that once a given bacterial species was established, other organisms might have less opportunity of settling down and multiplying; but, if the first species were suppressed by drugs or change in environment, new varieties of bacteria might readily supplant it. While this is pure speculation, it lends an additional discouraging note to the problem of treating chronic, long-standing urinary tract infection and emphasizes the urgency of definitive diagnosis and thorough treatment as early as possible, when permanent eradication of infection is frequently feasible by present-day methods.

REFERENCES

1. Birchall, R.: The responsibility of an internist in the treatment of pyelonephritis, J. Urol., 68:798-803, Nov. 1952.

2. Birchall, R., and Alexander, J. E.: Medical aspects of pyelonephritis, Medicine, 29:1-28, Feb. 1950.

3. Hopper, J., Jr., Jawetz, E., and Hinman, F., Jr.: Polymyxin B in chronic pyelonephritis: Observations on the safety of the drug and on its influence on the renal infection, Am. J. Med. Sc., 225:402-409, April 1953.

4. Hunter, T. H.: Bacterial endocarditis, Am. Heart J., 42:472-82, Sept. 1951.

5. Jawetz, E.: Infections with Pseudomonas aeruginosa treated with Polymyxin B, Arch. Int. Med., 89:90-98, Jan. 1952.

6. Jawetz, E., and Gunnison, J. B.: An experimental basis of combined antibiotic action (report to the Council on Chemistry and Pharmacy of the A.M.A.), J.A.M.A., 150: 693-95, Oct. 18, 1952.

7. Jawetz, E., and Coleman, V. R.: Laboratory and clinical observations on Aerosporin (Polymyxin B), Jour. Lab. & Clin. Med., 34:751-760, June 1949.

8. Jawetz, E., and Gunnison, J. B.: The determination of sensitivity to penicillin and streptomycin of enterococci and streptococci of the viridans group, J. Lab. & Clin. Med., 35:488-96, March 1950.

9. Longcope, W. T., and Winkewerder, W. L.: Clinical features of the contracted kidney due to pyelonephritis, Bull. Johns Hopkins Hosp., 53:255-87, 1933.

10. Mandel, E. E.: Renal medullary necrosis, Am. J. Med., 13:322-27, Sept. 1952.

11. Mansfield, J. S., Mallory, G. K., and Ellis, L. B.: The differential diagnosis of chronic Bright's disease, N.E.J.M., 229:387-95, 1943.

12. Ophuls, W.: A statistical survey of three thousand autopsies, Stanford Univ. Publ., Univ. Series, M. Sc., 1:127, 1926.

13. Pulaski, E. J., Baker, H. J., Rosenberg, M. L., and Connell, J. F.: Laboratory and clinical studies of Polymyxin B and E, J. Clin. Inv., 28:1028-31, Sept. 1949.

Conservative Therapy of Benign Uterine Bleeding

With Special Reference to the Use of Ergot

N. SPROAT HEANEY, M.D., and EARL HYMAN, M.D., *Beverly Hills*

• *Although operation frequently is carried out in cases of excessive uterine bleeding of benign origin, particularly if fibrous tumor is present, in many cases major surgical intervention could be averted by adequate conservative therapy.*

The authors have given Ergotrate® over long periods with good results in many cases and have noted no severe side effects. If this therapy fails, diagnostic dilatation and curettement sometimes reveals and removes the cause of bleeding.

If infection is a factor, use of sulfonamides or antibiotics sometimes has dramatic effect.

IT HAS LONG BEEN RECOGNIZED that many types of functional uterine hemorrhage or excessive bleeding of benign origin, whatever the cause, are frequently controllable by conservative treatment or minor surgical procedures. Yet there seems to be a tendency to resort to hysterectomy or irradiation without giving adequate trial to simpler measures.

Some of the common causes of excessive bleeding of benign origin are myomas and polyps, chronic cervicitis and endocervicitis, subinvoluted or atonic uterus, either postpartal or postabortal with or without adherent placental tissue, hyperplastic or polypoid endometrium, endocrinologic dysfunction, pelvic inflammatory disease, adenomyosis, endometriosis and the presence of some kinds of ovarian neoplasms. Of these causes, probably the most common are myomas and polyps, with submucous myomas and endometrial polyps the most likely to cause abnormal bleeding — usually excessive flow during menstrual periods.

Apparently there are some physicians and many laymen who believe that mere proof of the presence of a myoma in the uterus, even though it cause no symptoms, makes major operation imperative. Almost daily, gynecologists consult with patients who have already been advised by the referring physician that hysterectomy probably should be done immediately. It is not uncommon for the patient to say that some mention has been made of the likelihood of present or future malignant change. And once suspicion of that possibility has been aroused, very few women can calmly accept advice for other than surgical treatment.

Sarcomatous change is, in fact, exceedingly uncommon and usually warning is given by a sudden increase in the size of the tumor. Certainly it does not occur often enough to warrant indiscriminate removal of the uterus in every case in which there is a fibroid tumor in the organ. (This does not apply, of course, if the tumor is larger than a fetus in the fourth month or is obviously causing pressure symptoms owing to size or location.)

Like other observers,[1-3] the authors believe in a conservative approach—generally in watchful waiting and, if there is excessive bleeding, application of all known means to control it in the hope of avoiding operation. If conservative therapy is successful, the uterus is preserved for women who wish to have children, and for others the bleeding may be kept in control through the menopause when natural cessation of bleeding and involution of fibroid tumors takes place. Morover, if hysterectomy ultimately becomes necessary, a physician who has obviously tried to avoid it is more likely to have his advice followed when he recommends operation.

In cases in which extraordinary bleeding is not a complaint but small myomas are noted in the course of examination done routinely or in connection with some minor complaint, the physician should tell the patient of the condition, explain that she need not be fearful, let her know that operation probably will never be necessary, advise her to have examinations every six months and meanwhile to report any unusual symptoms promptly. If excessive bleeding is the chief complaint, however, and myomas are present and the uterus moderately enlarged, conservative therapy is indicated. Only if all other measures are ineffectual should operation be considered.

The authors have given Ergotrate® in many cases of bleeding of benign origin, sometimes continuing treatment for long periods, with good results.

Ergot has been commonly used by physicians for many years, chiefly in the treatment of postabortal or postpartal bleeding. But in general the drug has been employed with trepidation and to limited degree for short periods, probably owing to unfounded statements in early textbooks regarding toxic effects,

the development of gangrene of the extremities and other dire sequelae of long-continued administration. Certainly the value of the drug in the treatment of benign functional bleeding and bleeding caused by the presence of fibroid growths has been almost entirely overlooked.

One of the authors in more than forty years of administration of ergonovine maleate in adequate dosage for long periods has yet to observe gangrene or other serious effect from use of it. Occasionally a patient appears not to tolerate the drug, but in such cases there is only nausea or some other mild symptom that abates when treatment is discontinued; and in many instances the therapy can be resumed later without ill effect. Rarely, severe cramping follows each dose of ergonovine maleate; if it does, a submucous polyp must be suspected and use of the drug discontinued.

The dosage should be varied to fit the requirements in each case. The authors usually start with one 0.2 mg. tablet of Ergotrate® (1/320 grain) by mouth four times daily throughout the menstrual period. Then, depending upon the response, the dosage is adjusted. If there is no response or it is slow, the dosage is increased in amount—say to 0.4 mg. (1/160 grain) — and in frequency of administration. Sometimes in severe cases it may be necessary to begin giving the drug several days before the first day of the period. In cases of severe bleeding, other measures should also be carried out—rest in bed, application of an ice cap to the lower part of the abdomen, prescription of diet and of supplementary vitamins, administration of hematinic agents and treatment of blood dyscrasia if present. If the cervix is eroded or if cervicitis or endocervicitis is present, appropriate treatment must be given.

This therapy is not always effective, and even when it is, the desired results are not always obtained immediately. Ordinarily, improvement increases with each menstrual period and the amount of bleeding does not approach normal until treatment has been continued through four or five periods. As bleeding diminishes, the dosage may be reduced. In many instances fibroid formations appear to decrease in size during therapy.

The same general regimen often is effective also in treatment of benign bleeding owing to other causes — postpartal and postabortal bleeding, the bleeding of ovarian dysfunction and functional menorrhagia.

When the treatment described is not effective and myomas or other etiologic factors cannot be demonstrated, further search must be made for the cause and other means of therapy employed. Sometimes diagnostic dilatation and curettement may at once reveal and remove the cause—perhaps a remnant of placental tissue, or endometrial hyperplasia or polyps in the cervical canal. Often in cases of endocervicitis, as evidenced by swelling and patency of the cervical canal with profuse bleeding upon contact, administration of sulfonamides or antibiotics has dramatic results. Occasionally in such cases it may be necessary to strip the cervical canal with a very fine cautery tip, gently and carefully lest trauma cause stricture. In a surprising number of cases excessive bleeding will abate with effective treatment of chronic cystic cervicitis, cervical infection or hypertrophy of the cervix with Nabothian cysts. When cervical stenosis is the cause of bleeding, as it frequently is, dilatation is sometimes of benefit. It can be carried out in a physician's office with topical anesthesia.

Occasionally when bleeding does not diminish with administration of Ergotrate alone, the authors use a compound of Ergotrate, 0.2 mg., cotarnine chloride, 95.0 mg., and cottonroot bark, 95.0 mg., put into a capsule and given every 3 to 4 hours as necessary. This seems to have additional effect but it increases the cost of medication.

The authors are opposed to the use of estrogenic hormones[2-4] in cases of excessive bleeding, particularly in the presence of myomas or adenomyosis, on the ground that the patient may already have overgeneration of female sex hormones. And although they have had but limited experience with the use of androgens, the results observed have been very disappointing—no improvement or very short-lived benefit when the hormone was given in recommended dosage.

Believing that there is rarely if ever justification for destruction of ovarian tissue in the therapy of benign bleeding, the authors consider irradiation warranted only for malignant conditions. Since patients differ in degree of radiosensitivity, what might appear to be a relatively innocuous dose in one case might have very severe effect in another. In addition, there may be undesirable side effects such as cystitis, proctitis, or premature menopausal symptoms as a result of ovarian damage. Delayed effects many years after radium therapy have been observed, cervical stricture quite commonly. It is felt that when conservative therapy is not effective, vaginal hysterectomy is preferable to irradiation even though the patient be a poor surgical risk.

9730 Wilshire Boulevard.

REFERENCES

1. Frank, R. T.: Operative vs. nonoperative procedures for uterine fibroids, J.A.M.A., 140:1001, July 23, 1949.

2. Greenblatt, R. B.: The management of functional uterine bleeding, Med. Clin. of North Amer., 34:1551, Sept. 1950.

3. Payne, F. L.: The treatment of uterine fibroids, Surg. Clin. N. Amer., 28:1445, Dec. 1948.

4. Schumann, E. A.: Postmenopausal vaginal bleeding, West. J. Surg., Gynec. & Ob., 60: 49-52, Feb. 1952.

Postoperative Parenteral Nutrition

RICHARD E. GARDNER, M.D., and
HAROLD A. HARPER, Ph.D., San Francisco

• Parenteral feeding is not an adequate substitute for oral feeding. Water and electrolytes can readily be supplied parenterally, but not all necessary nutrients. To provide the 2,000 to 2,500 calories per day needed for adequate energy and to avoid oxidation of protein, concentrations of dextrose as great as 25 per cent with an additional 5 per cent of ethyl alcohol have been used parenterally with success. Fat emulsions have been given intravenously with some success, but undesirable reactions in as many as 16 per cent of patients have been reported. Protein may be given as amino acids in solution with 10 to 15 per cent dextrose. Water-soluble vitamins may be lost through diuresis if administered intravenously; of these vitamin C is necessary to healing of wounds and appears to have special value in reactions to stress. If fat nutrition is impaired, deficiency in fat-soluble vitamins is to be expected; of these, vitamin K is important to production of prothrombin and therefore especially necessary to recovery from operation or injury.

AMONG THE CONDITIONS retarding postoperative convalescence in which the importance of nutritional deficiencies has been emphasized in recent observations are retarded wound healing,[5] decreased resistance to infection,[16] anemia, increased susceptibility to hemorrhagic shock,[8] and reduction in the activity of enzymes.[2] Such deficiencies may be the result of prolonged dietary inadequacy or of recent nutritional impairment occasioned by acute illness. Moreover, certain operations impose physiological stress which increases the nutritional needs of the patient at a time when oral feeding is contraindicated or is inadequate. Water and electrolytes can be readily supplied parenterally, but not all necessary nutrients can be. Care must be taken, therefore, to detect nutritional deficiencies early and correct them promptly. It is with supplying the nutritional elements that are more difficult to administer than water and electrolytes that this presentation is concerned.

Special nutritional regimens are indicated for patients undergoing multiple operations, in order to counteract the catabolic effect of the procedures. Resumption of special nutritional measures may be needed in event of relapse. Application of a sound nutritional plan will prevent in part the loss of weight and physical debility which often occur in early convalescence from injury or disease. However, it is necessary also to avoid preventable loss of blood or faults in operative technique which may complicate the nutritional problem, for even the most thorough postoperative measures are not adequate to compensate for them. The early resumption of normal eating is the most important factor in maintaining the patient's nutrition.

Nutritional requirements include six major components of the diet: Water, minerals, carbohydrates, fats, proteins and vitamins. Carbohydrates, fats and proteins are sources of energy (calories) and provide for growth and repair of tissues. Water, minerals and vitamins do not yield energy, but are essential elements of the chemical mechanisms for the utilization of energy and for the synthesis of various essential metabolites such as hormones and enzymes. The minerals are also incorporated into the structure of the tissues and, in solution, play a role in water metabolism and acid-base equilibrium as well as in other important aspects of metabolism.

Caloric requirements. Energy for physiological processes is provided by the combustion of carbohydrates, fats and proteins, but carbohydrates and fats are physiologically the most economic sources. Proteins serve primarily to provide for tissue growth and repair but it is important to emphasize that they too are metabolized for energy if the caloric intake from other foods is inadequate. Normal, healthy adolescents or adults at rest require 25 calories per kilogram of body weight per day (approximately 1,600 calories); young infants, 60 calories per kilogram; older infants, 55 calories per kilogram; children, 30 calories per kilogram per day. During periods of growth or convalescence extra calories are needed. In special circumstances such as infection accompanied by elevated temperature, or in heightened metabolism from any cause

From the Division of Surgery, University of California School of Medicine, San Francisco.

Part of a Symposium on Nutrition and Electrolytes presented before the Section on General Surgery at the 82nd Annual Session of the California Medical Association, Los Angeles, May 24 to 28, 1953.

the caloric demand is further increased. These factors raise the maintenance caloric requirements for adolescents and adults to 30 to 35 calories per kilogram per day (2,000 to 2,500 calories).

Carbohydrate requirements. Carbohydrates are depended upon as an immediate source of energy, but the ability of the body to utilize parenterally administered sugar is limited. According to Lockhart and Elman[6] it is usually not desirable to infuse dextrose intravenously at a rate exceeding 0.5 gm. per kilogram of body weight per hour, since considerable glycosuria, diuresis and consequent dehydration are likely to result. As the usual solution of dextrose—50 gm. per liter—supplies only 200 calories per liter, more concentrated solutions have been tried and found to be well tolerated if administered very slowly. Spencer and Beal[11] reported that in trials with a 25 per cent solution of dextrose 93.8 per cent was retained and that the risk of phlebitis at the site of infusion was "minimal." They administered the solution at a rate of 40 to 60 gm. per hour, a faster rate than that recommended by Lockhart and Elman. None of the subjects in their studies, however, was in the immediate postoperative period.

The use in parenteral nutrition of so-called "invert sugar," which is a mixture of dextrose and fructose prepared by the hydrolysis of cane sugar, has recently been investigated.[4, 12, 13, 14] Proponents of invert sugar believe that it is more efficiently utilized than an equal quantity of dextrose, but in practice the difference does not seem to be significant.

Ethyl alcohol, which supplies about 5.6 calories per gram, is sometimes added to solutions for parenteral administration, but as the capacity of the body to utilize alcohol is limited and the cumulative effects may be undesirable, alcohol should be used in concentrations no greater than 5 per cent, and only in combination with dextrose. Spencer and Beal[11] added 5 per cent alcohol to 25 per cent of dextrose in the solution used in their studies, which was equivalent to 1,280 calories per liter.

Fat requirements. As fats have a caloric value (9 calories per gram) more than twice that of carbohydrates or proteins, methods of parenteral administration have been carefully explored. Although fat emulsions have been given intravenously with generally satisfactory results, there are several obstacles to widespread use of them. The preparation of a reproducible, pyrogen-free emulsion which remains stable in storage has not yet been achieved. The incidence of reactions to lipid infusions was as high as 16 per cent in the experiments of Shafiroff and Mulholland.[10] These reactions included headache, chills, nausea, vomiting and fever. The fever may be a "thermogenic reaction" to injection of fat at a rate which exceeds the capacity of the body to utilize it. Orally administered fat is normally stored in fat depots and slowly oxidized in accordance with the needs of the body. It is possible that if large quantities of fat are given intravenously, storage cannot be adequately accomplished and consequently rapid oxidation occurs, with resultant evolution of excessive heat.[8] This hypothesis is supported by the occurrence of ketonemia during the infusion of fat.

No notable damage to the liver, spleen or kidneys has been ascribed to the use of fat emulsions.

Protein requirements. In addition to the minimal protein required for regular replacement of tissue, the amount needed in postoperative convalescence, although highly variable, may be safely assumed to be greater than the normal daily requirement of 1 gm. per kilogram of body weight—in some patients 2 to 4 gm.[1, 15] Furthermore, if the "sparing action" of non-protein sources of energy is not adequate—that is, if these sources do not provide the full energy requirement of the body—protein is converted into energy rather than used for tissue synthesis. For example, Riegel and co-workers[9] found that in the immediate postoperative period a daily intake of 130 gm. of protein and 2,000 calories was needed for positive nitrogen balance.

As previously indicated, the usual regimen of parenteral nutrition does not provide sufficient calories; the parenteral administration of amino acids, therefore, has not proved to be an adequate method of maintaining protein requirements. For effective use, amino acids must be given in a solution with 10 to 15 per cent dextrose. Three liters of such solution with 5 per cent amino acids would approach the recommended intake of protein and calories. As such a solution is hypertonic, and as amino acids must not be administered at a rate faster than 50 gm. in four hours, the solution must be given very slowly. These factors greatly limit the usefulness of parenterally administered amino acids. However, in view of the well-documented need for individual amino acids in a variety of important metabolic functions other than protein synthesis, it would seem that when parenteral nutrition is needed for more than two or three days, at least 50 to 100 gm. of amino acids per day might well be added to the nutritional regimen.

Vitamin requirements. It is unnecessary to give vitamin preparations routinely after operation, although such supplementation is of course advisable both before and after operation if there is evidence of preoperative deficiency. Vitamins should also be given during convalescence complicated by mal-

nutrition, by decreased utilization of vitamins, by acceleration of metabolism as in fever and infection, or by reaction to stress.

Normal losses of water-soluble vitamins are increased by the diuresis that follows administration of parenteral fluids. The recommended daily postoperative doses of the most important of these vitamins are: thiamine (B_1), 5 to 10 mg.; riboflavin (B_2), 5 to 10 mg.; nicotinic acid (niacin), 50 to 100 mg.; ascorbic acid (vitamin C), 100 to 250 mg. As the loss of water-soluble vitamins in the urine is considerable when they are administered intravenously, it is preferable to inject them intramuscularly or subcutaneously if they cannot be taken by mouth.

There is much evidence that vitamin C has a special biochemical function in the reaction of the body to stress such as toxic infection, fever, burns and other trauma. It is also directly involved in the healing of wounds. In certain cases, therefore, a daily intake of 500 to 1,000 mg. of vitamin C may be indicated.

Deficiencies in fat-soluble vitamins are to be expected if there is any defect in fat digestion or absorption. Most important in this regard is a deficiency of vitamin K, which leads to hypoprothrombinemia with consequent delay in the rate of blood clotting. In this condition it is necessary to raise the prothrombin level to at least 60 or 70 per cent of normal. Vitamin K should be given intramuscularly both before and after operation, usually 4 mg. daily. It should be remembered that vitamin K deficiency is not always accompanied by jaundice.

When nutrition is limited to parenteral feedings or when the food intake is restricted for a long time, it is probable that, in addition to the vitamins already recommended, vitamin A (5,000 to 10,000 units), pyridoxine (B_6) (2 mg.) and pantothenic acid (20 mg.) will be needed daily.

REFERENCES

1. Benditt, E. P., Woolridge, R. L., and Stepto, R.: The dynamics of protein metabolism. II, the relationship between the level of protein intake and the rate of protein utilization by protein-depleted men and rats, J. Lab. and Clin. Med., 33:269, 1948.

2. Cannon, P. R.: Some Pathological Consequences of Protein and Amino Acid Deficiencies, Thomas, Springfield, 1948.

3. Lambert, F. G., Miller, J. P., and Frost, D. V.: Febrile response following intravenous administration of fat, Am. J. Physiol., 164:490, 1951.

4. Lawton, B. R., Curreri, A. R., and Gale, J. W.: Use of invert sugar solutions for parenteral feeding of surgical patients, Arch. Surg., 63:561, 1951.

5. Localio, S. A., Chassis, J. L., and Hinton, J. W.: Tissue protein depletion, a factor in wound disruption, Surg., Gyn. & Obst., 86:107, 1948.

6. Lockhart, C. E., and Elman, R.: The effect of intravenous glucose and amino acids on glycosuria and urinary outputs in humans, Surg., Gyn. & Obst., 88:97, 1949.

7. National Academy of Sciences-National Research Council: Therapeutic Nutrition, Washington, D. C., 1952.

8. Ravdin, I. S., McNamee, H. G., Kamholz, J. H., and Rhoads, J. E.: Effect of hypoproteinemia on susceptibility to shock resulting from hemorrhage, Arch. Surg., 48:491, 1944.

9. Riegel, C., Koop, C. E., Drew, J., Stevens, L. W., and Rhoads, J. E.: Nutritional requirements for nitrogen balance in surgical patients during the early postoperative period, J. Clin. Invest., 26:18, 1947.

10. Shafiroff, B. G. P., and Mulholland, J. H.: Effects on human subjects of intravenous fat emulsions of high caloric potency, Ann. Surg., 133:145, 1951.

11. Spenser, F. C., and Beal, J. M.: The use of a solution of twenty-five per cent glucose and five per cent alcohol in parenteral nutrition, Ann. Surg., 135:234, 1952.

12. Weichselbaum, R. E., Elman, R., and Lund, R. H.: Comparative utilization of fructose and glucose given intravenously, Proc. Soc. Exper. Biol. and Med., 75:816, 1950.

13. Weinstein, J. J.: Parenteral therapy with invert sugar, Ann. West. Med. and Surg., 4:373, 1950.

14. Weinstein, J. J., and Lane, G. F.: Rapid infusion of invert sugar, Med. Ann. Dist. of Columbia, 20:186, 1951.

15. Werner, S. C., Habif, D. V., Randall, H. T., and Lackwood, J. S.: Postoperative nitrogen loss; a comparison of the effects of trauma and of caloric readjustment, Ann. Surg., 130:688, 1949.

16. Wohl, M. G., Reinhold, J. G., and Rose, S. B.: Antibody response in patients with hypoproteinemia, Arch. Int. Med., 83:402, 1949.

Cytologic Detection of Cervical Cancer

Four Years' Experience with Routine Smear Examination in Private Practice

PURVIS L. MARTIN, M.D., THOMAS A. SLATE, M.D., and JOHN W. MERRITT, B.S., *San Diego*

• *Simplified Papanicolaou smear techniques appear to be adaptable to private clinical practice when experienced cytodetection laboratory facilities are available. A private physician's office seems potentially an efficient, economical and practical place for detection of cervical cancer by use of the smear technique as a routine part of examination of patients.*

In a series here reported upon, examination of 11,207 cervical smears taken at the first examination of patients of all ages led to diagnosis of unsuspected malignant disease in 80 cases—in all instances at a stage when it should be easily curable. Cancer was not detected in examination of 6,060 smears taken later from women who had had a "negative" smear at the time of first examination, which seems to indicate that the first screening was reasonably accurate.

In a few cases, early cancer was detected when smears were reported as "atypical" or "suspicious." Such reports demand as careful follow-up as do "positive" reports.

There are dangers and limitations in widespread clinical application of screening by this method. Care must be observed in the development of programs for its use lest the potential benefits in early detection be outweighed by the dangers from misuse.

BETTER CONTROL OF CERVICAL CANCER still depends primarily on earlier detection. The publication in 1943 of the well known Papanicolaou and Traut[12] monograph on vaginal smears seemed to give promise of widespread early detection. Since then, many research center[1-3, 5-9, 13] and several cancer detection centers[4, 10] have reported a high degree of success in early cancer detection using various modifications of the original Papanicolaou-Traut technique. Yet population screening with this method is still not generally available. Economic and technical obstacles, shortage of trained cytologists and valid fears of misuse have limited the use of this means of detection. Cervical cancer remains a disease which, more often than not, is already lethal by the time it is diagnosed. A method of control seems at hand, yet practical techniques for widespread application of this method have not been fully worked out.

The study herein reported upon was started nearly four years ago in an effort to adapt the use of Papanicolaou smears to private clinical practice and then to test the private physician's office as a cervical cancer detection center. It seemed reasonable that every physician's office where women are accustomed to go should be the most available and economical cancer detection center. Accordingly, attempt was made to devise and to test a procedure of technician screening that would be simple and convenient enough for any physician to use, economical enough to pay its own way in private practice, yet accurate enough to detect unsuspected cervical cancer in a high proportion of cases.

Last year a preliminary report was made on the early development of this program, the details of the simplified technique, and the number of unsuspected cases of cancer detected in a series of 7,530 smears.[11] From the preliminary study it was concluded that when adequate laboratory facilities were available the office of a physician in private practice could be a practical center for screening for cervical cancer. The system used was economically satisfactory to both physician and patient. With the simplified technique that was used, unsuspected intra-epithelial or early invasive cancer was detected in 43 women observed in private practice. In all instances the lesion was at a stage when it should be easily curable. All adult age groups were represented. It was further observed that routine smears on all women, regardless of age or complaint, produced as high a yield as occasional smears taken "when indicated by age or the appearance of the cervix."

The study has grown since that report and now includes for detailed analysis 17,267 smears from more than 11,000 private patients who are representative of the adult female population of San Diego

Presented before the Section on Obstetrics and Gynecology at the 82nd Annual Session of the California Medical Association, Los Angeles, May 24 to 28, 1953.

County in all but the lowest economic brackets. Eight collaborating gynecologists who are members of the Gynob Clinical Group but practice individually, now routinely obtain smears of material from the cervix of all patients the first time they examine them, and all patients are urged to have smears taken annually thereafter.

The technique used has remained essentially as previously reported. Without previous preparation and without regard for recent douching, an ordinary tongue blade is used to scrape the region of the external os. Collected material is spread thinly on a slide which is dropped wet into ether and alcohol, then later sent to the laboratory. This step in a routine pelvic examination takes but a moment, but during that moment the patient is told: "This is a routine test for cancer. It applies to the cervix only. It should be repeated annually." Later, if the smear is "negative" a form note is sent from the physician's office to the patient, reporting that the smear gave no evidence of cancer of the cervix and again stressing the limits of relative protection: For the cervix only and for a year only. A charge of $3.50 per slide brings the test within the reach of practically every patient and yet is enough to cover the laboratory cost with the present volume.

In the laboratory of the Gynob Clinical Group the smears are stained and examined by specially trained technicians, who classify them as "negative," "atypical," "highly atypical," "suspicious," or "positive." These classes correspond to Papanicolaou classes I, II, III, IV and V, but the terms were chosen because they seem to be more suggestive to clinicians receiving the reports. Slides in the last three classes are reexamined by a physician cytologist. In any case in which the slide is confirmed as highly atypical, suspicious or positive, biopsy specimens are taken from several sites or conization with a scalpel is carried out. For smear screening the authors have coined the term *cytodetection* as preferable to *cytodiagnosis,* since in all cases diagnosis is made by a certified pathologist from tissue preparations, not smears. Treatment is never started until a diagnosis has been made by biopsy.

In the interest of practical efficiency the original practice of making three slides for each patient was abandoned. At first, material was obtained by vaginal aspiration, by cervical scraping and by swab from the cervical canal. It was found, however, that an experienced technician could process about 600 slides a month and that making three slides for each patient barely affected the number of cases detected, yet reduced the technician's capacity to 200 patients per month. Also, it trebled the cost per patient. Since the principal yield in detection of unsuspected cancer comes from cytologic examination of material from patients not previously examined, study of single slides of material scraped from the cervix in 600 cases will detect almost three times as many cancers as study of three slides from each of 200 patients. Moreover, it was observed that endometrial cancer was not consistently detected by examination of material aspirated from the vagina or swabbed from the cervical canal. Fortunately, endometrial cancer usually causes abnormal bleeding which leads to curettement and diagnosis before a lethal stage has been reached. For cervical cancer, on the other hand, it is felt that examination of smears is more accurate than random biopsy, for an early lesion often is not visible and tissue excised for biopsy may be taken from the wrong place to detect it.

Gradually, as experience has widened, series of smears beyond the first have been accumulated in a number of cases, which serves as a check on the accuracy of the original screening. Demand for "cancer detection smears" seems to be growing among women in San Diego. Other local physicians are taking smears and other laboratories are reporting on them. Since not only great benefits but also dangers, limitations and pitfalls are apparent, the authors take this opportunity to review their now widened experience and appraise the results, good and bad.

RESULTS IN A 4-YEAR PERIOD

In a period of four years, 17,267 smears of material scraped from the cervix of patients observed in private practice were examined. Of that total, 11,207 were from women who had not previously had examination of smears, and in 112 cases cancer was detected by the cytologic examination. In 80 of those cases, cancer was not suspected until the slides were examined; and in 74 of the 80 the growth was intra-epithelial, in 6 in an early invasive stage. In 25 of the detected cases, cancer was suspected on the basis of clinical observations or was known to be present at the time the smear was taken, and in all those cases in which there were clinical manifestations the growth was invasive. In seven cases the cancer was adenocarcinoma of the fundus of the uterus. The other 6,060 slides were annual repeat smears from women who had had at least one previous smear examination, and cancer was not found in any case.

In the entire series there were 26 cases in which the slides were reported as positive for cancer which was not confirmed by biopsy ("false positive") although in many of these cases basal cell hyperplasia explained the abnormal smears. In two cases there were "false negative" reports, which will be discussed later.

As has been said, all patients are urged to have a smear examination each year. In four years many

TABLE 1.—*Atypical and suspicious smears—false positives and false negatives*

Smear Report	Lost to Follow-Up	Neg. Biopsy (False Positive)	Leukoplakia or Dyskeratosis	Preinvasive Unrecognized	Invasive Unrecognized	Invasive Recognized
Neg. (I-II)	....	....	....	1	? 1	....
Highly atypical (III)	4	4	9	5	....	0
Suspicious (IV)	7	5	9	9	1	2
Positive (V)	9	7	19	60	5	23

patients had two, three or four. The fact that in 6,060 such examinations there has been no "positive" finding when the original result was "negative" seems an important confirmation of the accuracy of the initial screening. If many cancers were being missed on the first smear, certainly a few "positives" would show up in more than 6,000 repeat smears taken a year or more later. The authors are beginning to doubt that even an annual smear examination is necessary once there is "negative" finding. Perhaps the interval could safely be extended to two years or more.

A few patients who had "suspicious" or "positive" smears were not examined further by the authors, owing to their moving away from the area or switch to other physicians. Included among them were five who had "positive" smears and on whom deep cervical cauterization was carried out at the time of the original examination. Subsequent follow-up by smear and biopsy gave no evidence of cancer. Undoubtedly, unrecognized intra-epithelial cancer often is cured by ordinary cautery. Since this observation was made early in the study, the authors now rarely cauterize the cervix before a smear is reported as "negative."

In a number of cases in which smears were reported as "suspicious" or "positive," no evidence of malignant change could be found in biopsy specimens. Careful and prolonged observation is indicated in such circumstances. In 18 cases "atypical," "suspicious" and "positive" smears led to detection of basal hyperplasia or dyskeratosis (Table 1) which is thought by some investigators to be precancerous or a precursor of intra-epithelial cancer which is to develop later.

Of greatest importance in smear screening is the "false negative"—cancer missed by smear examination. In the present series this is known to have occurred in one case, and probably in another. In one of those cases the smear was reported as "slightly atypical." Curettement and conization were done on clinical indications and intra-epithelial carcinoma was diagnosed by biopsy. On review, the smear was classified as "suspicious." In the other case, six months after the patient had a "negative" smear on the first visit it was reported from another city that she had early invasive inverting cervical cancer. There were no other known instances of "false negative."

In several cases smears that were "atypical" and "suspicious" rather than "positive" led to detection of preinvasive cancer, and in one instance to detection of early invasive cancer whose presence was not previously recognized. It is now felt, therefore, that biopsy should be done when smears are reported as atypical or suspicious as well as when they are classified as positive.

In ten cases in the present series carcinoma of the fundus of the uterus was diagnosed; it was detected by smear examination in seven cases and missed by that method in three. The presence of the disease was suspected clinically in all the cases, owing to abnormal bleeding. It would appear that cervical smears alone should not be relied upon for detecting fundal carcinoma.

LIMITATIONS AND DANGERS

With increasing use of the smear technique, not only by the Gynob Clinical Group but by other physicians as well, some of the limitations and dangers of use of the method by physicians in private practice have become apparent. Women hear of the "cancer detection smear" and often request it from physicians who are not prepared. Inexperienced study of smears may result in false security and continued growth of cancer from a curable to an incurable stage. Smears must not replace biopsy for diagnosis of suspicious lesions.

In a case observed by one of the authors, adenocarcinoma was suspected clinically but the report on a smear was "negative" and inadvertently a report to that effect was sent to the patient. Thus, with false security, she did not keep an appointment for curettement and for a time could not be traced. Treatment was delayed two months.

It is known that in some instances physicians advised hysterectomy solely because of a "suspicious" smear. On the other hand, some patients who did not have cancer but who had smears reported as "suspicious" or "positive" suffered severely from cancerophobia before the ultimate diagnosis was reached.

DISCUSSION

It is difficult to estimate the number of cases in the present series in which the life of the patient was saved by the results of cytologic examination, for in most instances the lesion was intra-epithelial

and the complete life history of intra-epithelial cancer is not known. However, it seems reasonable to believe that by detection of unsuspected yet easily curable cancer in 80 cases, a number of lives must have been saved. Added to this obvious benefit is the peace of mind of more than 11,000 women from 17,000 "negative" reports.

To the authors, the taking of smears has become so much a part of routine examination of patients when they are observed for the first time that it would seem difficult to do without them. After four years the entire program as here outlined is more satisfactory than ever. On the other hand, any such screening program must be developed with care and caution. The potential benefit is so great that premature misuse must not be permitted to bring discredit to the method.

One valid obstacle to screening of the population in general in research centers and in cancer detection centers has been the high cost per detection. However, in the authors' experience with the screening method as adapted to use in private practice, the cost is all willingly borne by the patients, with rare exceptions. The value to any woman of a negative report seems to be equal to the small cost. Therefore, when an occasional smear is reported as "positive" and cancer is detected, the cost per detection is the present cost of preparing and examining one slide: $3.50.

2105 Fifth Avenue.

REFERENCES

1. Ayre, J. E.: Am. J. Ob. & Gyn., 51:743, 1946.

2. Cuyler, W. K., Kaufmann, B. A., Carter, B., Ross, R. A., Thomas, W. L., and Palumbo, L.: Am. J. Ob. & Gyn., 62:262, 1951.

3. Foote, F. W., and Li, K.: Am. J. Ob. & Gyn., 56:335, 1948.

4. Garland, L. H.: Cancer detection centers—the experience to date in California, Calif. Med., 72:99, Feb. 1950.

5. Graham, R. M., and Meigs, J. V.: Am. J. Ob. & Gyn., 58:843, 1949.

6. Haynes, D. M., Brown, W. W., Hermes, R. L., Bates, G. R., and Mengert, W. F.: J.A.M.A., 148:457, Feb. 1952.

7. Hecht, E. K.: Am. J. Ob. & Gyn., 64:81, 1952.

8. Kernodle, J. R., Cuyler, W. K., and Thomas, W. E.: Am. J. Ob. & Gyn., 56:1083, 1948.

9. Kraushaar, O. F., Bradbury, J. T., and Brown, W. E.: Am. J. Ob. & Gyn., 58:447, 1949.

10. L'Esperance, E. S.: Bul. N. Y. Acad. Med., 23:394, 1947.

11. Martin, P. L., Slate, T. A., and Merritt, J. W.: West. J. Surg., Ob. & Gyn., 61:102, March 1953.

12. Papanicolaou, G. N., and Traut, H. F.: Diagnosis of uterine cancer by the vaginal smear, The Commonwealth Fund, New York, 1943.

13. Skapier, J.: Am. J. Ob. & Gyn., 58:366, 1949.

CASE REPORTS

- **Appendiceal Stones Simulating Ureteral Calculi**
- **Fat Emulsions as Dietary Supplement**
- **Electrocardiographic Changes Occurring with Trivalent Antimony Compounds During Therapy of Schistosomiasis**

Appendiceal Stones Simulating Ureteral Calculi

THOMAS M. SAWYERS, M.D., and
DAVID D. ROSENFELD, M.D., *Fontana*

REPORTS AS TO THE INCIDENCE of calcified stones in the appendix vary widely. Bunch and Adcock[1] observed only one case in 2,000 patients with appendicitis. Steinert[5] noted appendiceal calculi in ten of 104 patients who had appendectomy; and in seven of the ten cases the diagnosis was made before operation. More recently Felson and Bernhardt[2] reported ten cases among 300 in which appendectomy was done. The importance of early correct diagnosis of the condition was emphasized many years ago by Murphy,[3] who noted that perforation occurred quite early in the course of obstructive appendicitis and reported the occurrence of perforation in half of the cases in one series of patients with obstruction.

Although appendiceal stones may have certain radiographic features that help to distinguish them, differentiation from ureteral calculi is not always easy. The similarity of symptoms and radiographic appearance has been commented on since 1908.[4] Felson and Bernhardt outlined several helpful radiographic features of appendiceal stones: (1) They are usually single, and almost always laminated. (2) They are usually over 1 cm. in diameter. (3) In stereoscopic views or in films taken in various oblique positions, they always appear close to the cecum; and they may be in a position that is obviously outside the course of the ureter.

These features, in addition to the history, will usually distinguish appendiceal from ureteral stone. In the case herein reported, however, the symptoms were those of ureteral colic and the appendiceal stones observed at operation did not have the usual characteristics. Radiographically they were not laminated, they were less than 1 cm. in size, and they were directly in the course of the distal right ureter. An excretory urogram was required to make certain they were not in the urinary tract.

CASE REPORT

A white woman 39 years of age was admitted to hospital in severe pain that had begun about seven hours previously as severe cramping pain in the right upper quadrant of the abdomen. The pain radiated into the epigastrium and was shortly followed by nausea and vomiting. After about an hour and a half the pain eased and the patient drove a car to take her husband to work. Approximately 20 minutes later she had a normal bowel movement. Two hours later she was found lying on the floor doubled with pain which continued until admittance to hospital. The pain was described as colicky in nature, coming in waves, and rapidly building to a peak intensity. It slowly became less severe but never abated completely. The pain was localized to the right of the umbilicus, did not cross the midline or radiate into the flank or groin. The patient vomited many times before admittance and this did not affect the pain. There was no history of hematuria, dysuria, pyuria or urgency, of chills or fever, or of passing pus, blood or mucus by rectum. The last menstrual period had occurred two weeks previously and had lasted the usual four days with the normal amount of flow.

When examined the patient was pale, sweating and doubled with extreme pain in the right side of the abdomen. The pulse rate was 108 per minute and the blood pressure was 120 mm. of mercury systolic and 86 mm. diastolic. There was generalized muscular rigidity over the abdomen, with tenderness most pronounced at McBurney's point. Extreme rebound tenderness was referred to the right lower quadrant from all quadrants of the abdomen. No masses or organs were palpable. Peristalsis was absent. Upon pelvic examination the uterus was observed to be small and anteflexed. Except for bilateral tenderness no abnormality was noted in the adnexae. The cervix was somewhat cystic. Bilateral tenderness was noted on rectal palpation.

A specimen of urine taken by catheter was clear and alkaline with a specific gravity of 1.023. It contained no albumin and no sugar. Four to six pus cells per high power field and occasional squamous epithelium cells were noted in microscopic examination of the urine. Erythrocyte content of the blood was 4.2 million per cu. mm. and the hemoglobin value was 86 per cent. Leukocytes numbered 22,300 per cu. mm.—78 per cent polymorphonuclear cells, 19 per cent lymphocytes and 3 per cent monocytes.

In a roentgenogram of the abdomen minimal ileus of the small bowel and the presence of gas in the colon were noted. Within the pelvic brim there were two non-laminated calcifications on the right side, one of them 4 mm. and the other 6 mm. in diameter. By intravenous pyelography it was observed that the calcifications were outside the course of the right ureter (Figure 1). A diagnosis of appendicitis with perforation and spreading peritonitis was made.

A right perirectus incision was made in the abdomen and when the peritoneum was opened free pus was observed between all loops of the small intestine. The appendix, which lay mesial to the cecum, was gangrenous and ruptured at the lower one-third. The larger calcification protruded through the opening in the appendiceal wall and when the appendix was lifted from its bed the calculus fell into the surgeon's hand. The smaller stone was palpable in

From the Departments of Surgery and Radiology, Kaiser Fontana Hospital Association, Fontana, California.

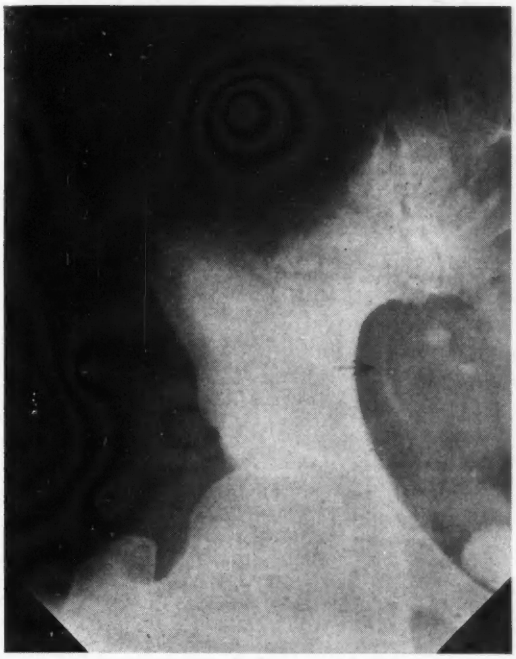


Figure 1.—Portion of the intravenous pyelogram showing relation of calculi to dye-filled ureter (arrow) within the pelvis.

the lumen of the appendix. The appendix was removed in the routine manner. One million units of aqueous penicillin G and 1 gm. of streptomycin were instilled into the peritoneal cavity. The incision was closed without drainage. Continuous gastric suction was applied and the patient was given fluid and antibiotics intravenously. Recovery was uneventful.

The appearance of the calculi in a roentgen film made of them after removal was identical with that seen in the preoperative roentgenograms. Sectioned, the stones were observed to be of laminated crystalline-like structure, yellow in color, and fairly homogeneous throughout.

SUMMARY

A case is reported in which appendiceal calculi simulated the roentgen appearance and the symptoms of ureteral stones. By intravenous pyelography it was determined that the stones lay outside the course of the ureter. Appendectomy was carried out and the stones were found in the appendix.

REFERENCES

1. Bunch, G. H., and Adcock, D. F.: Giant faceted calculus of the appendix, Ann. Surg., 109:143-146, Jan. 1939.

2. Felson, B., and Bernhard, C. Melvin: The roentgenologic diagnosis of appendiceal calculi, Radiology, 49:178-191, Aug. 1947.

3. Murphy, J. B.: Appendiceal concretion producing ulceration, perforation and acute peritonitis, S. Clin. N. A., 4:28-33, Feb. 1915.

4. Seelig, M. G.: Appendicitis resembling ureteral calculus, Surg., Gynec., and Obst., 7:485-486, Oct. 1908.

5. Steinert, R., Hareide, I., and Christiansen, T.: Roentgenologic examination of acute appendicitis, Acta Radiologica, 24:13-37, 1943.

Fat Emulsion as Dietary Supplement

CONSTANTINE T. KHLENTZOS, *San Francisco*

ALTHOUGH FAT is a satisfactory source of energy to supplement inadequate nutrition without supplying too much bulk, since it contains 9 calories per gram as opposed to 4 calories per gram of protein or carbohydrate, many fat diets are unpalatable and produce a feeling of fullness.

Van Itallie and co-workers[2] reported that fat emulsion as a food was well tolerated and assimilated by normal persons and that nitrogen and potassium deficits were overcome as a result of increased fat intake.

Forbes and Swift[1] observed that the specific dynamic action of any diet is affected by the proportions of protein, fat and carbohydrate it contains and that the high specific dynamic action of protein is retarded more by fat than by any other concomitant nutrient. Thus the caloric efficiency of a diet is considerably improved by the addition of fat, which reduces the loss of energy in utilization.

Four cases are here reported in which diet was supplemented with fat emulsion. The preparation used* is palatable and acceptable because of the small size of its particles. It is readily absorbed and utilized by both adults and children. Containing 40 per cent fat and 10 per cent glucose, it has 4 calories per milliliter, or 120 calories per ounce.

In each case urine specimens were taken every 24 hours and were pooled for analysis at 72-hour intervals. Nitrogen intake was estimated from the protein content of the diet. Urinary nitrogen content was determined by the Kjeldahl method.

CASE 1: A 22-year-old unmarried white woman was admitted to hospital with the chief complaint of loss of 40 pounds in weight and amenorrhea for the past five years. Menstruation had begun at the age of 15 years and had been regular. At the age of 16 the patient began to overeat and attained a weight of 135 pounds. A year later the weight declined to 120 pounds (it was estimated that the weight should have been 125 pounds) and amenorrhea developed. After treatment with vitamin injections and desiccated thyroid there was some gain, but after the patient completed high school the weight again began to decline, this time to 110 pounds, and the decline continued despite medical treatment. The patient began to work as a file clerk. During the five months before admittance to hospital the weight declined from 106 pounds to 85 pounds. At a clinic a diagnosis of anorexia nervosa was made and the patient was referred for psychiatric treatment, which after two visits she refused to continue. Another physician then admitted her to hospital for treatment of malnutrition.

On physical examination, although the flesh was observed to be wasted, there was no muscle weakness. The breasts were well developed and pubic and axillary hair were normal. The blood pressure was 106 mm. of mercury on systole and 74 mm. on diastole.

Erythrocytes numbered 4,650,000 per cu. mm. The hemoglobin value was 82 per cent. Leukocytes numbered 10,700 per cu. mm.—64 per cent polymorphonuclear cells and 42 per cent lymphocytes. Blood cholesterol content was 261 mg. per 100 cc. The number of eosinophils was not reduced after administration of corticotropin (Thorne method). The non-protein nitrogen content was 29 mg. per 100 cc. The glucose tolerance curve was low and flat.

From the Departments of Medicine and Biochemistry, St. Mary's Hospital, San Francisco.

*Lipomul—oral was supplied gratis by the makers, Upjohn Company, Kalamazoo, Mich.

TABLE 1.—*Effect of addition of fat emulsion to diet of patient (Case 1)*

Period of Observation	Weight (lbs.)	Calories Added Daily to 2500 C. Diet in Fat Emulsion*	Nitrogen Ingested (gm. per day)	Urinary Nitrogen* (gm. per day)
1- 3	92½	....	14.4	14.9
4- 6	92½	....	14.4	14.0
7- 9	90	720	14.4	17.8
10-12	90	720	14.4	7.9
13-15	92	720	14.4	10.1
17-19	93½	720	14.4	12.6
22-24	94½	1,080	14.4	13.9
29-31	95½	1,440	14.4	9.0
33-35	99	1,440	14.4	12.8
42-44	103½	1,440	14.4	16.6

*Average for 24 hours derived from 72-hour determination.

The urine appeared normal. The urinary excretion of 17-ketosteroid was 1.8 mg. in 24 hours (normal for adult female, 5 to 15 mg.). No result was obtained by assay for urinary gonadotropin at 5, 50 or 100 mouse units (normal, 5 to 50 mouse units).

A diagnosis of Simmond's disease had been considered, but the final diagnosis was anorexia nervosa.

A diet rich in proteins with an average daily content of 2,800 calories was given for a month. Vitamins were injected intramuscularly every day and corticotropin and cortisone were administered separately. During the month the weight varied from 85 to 90 pounds; at the end of the month it was 87 pounds.

For the next 44 days the daily caloric intake was maintained at 2,500 calories and the daily protein intake at 90 gm. Protein retention was estimated from determinations of urinary nitrogen (Table 1). After a control period fat emulsion was added to this diet without increase in protein. The weight increased and excretion of nitrogen in the urine decreased to a new level of equilibrium.

As the intake of the fat emulsion was further increased, the urinary nitrogen declined further and then rose to a new level of equilibrium. The fat emulsion diet was continued for 40 days more. On discharge the patient weighed 113 pounds and the basal metabolic rate had increased from minus 47 to plus 19.

The fat emulsion had at first caused a sense of epigastric fullness, and when taken between meals had reduced the appetite for the next meal. The emulsion was therefore given immediately after the meal; in several days the patient became accustomed to this supplement and tolerated it well.

CASE 2: A 21-year-old white student nurse had had little appetite for several weeks because of depression over problems at home. Her weight had declined from 130 pounds to 112 pounds when she was accidentally scalded with hot coffee, incurring first and second degree burns. She was admitted to hospital. The injuries aggravated the depression and anorexia, and the patient was given a diet of 1,950 calories including 90 gm. of protein. After a control period she was given 2 ounces of fat emulsion after each meal; 18 days later the supplement was increased to 3 ounces.

Nitrogen ingestion was estimated at 14.4 gm. per day. Urinary nitrogen excretion, which was 10.8 gm. per day during the control period, dropped to 4.0 gm. per day 24 days after the fat supplement was begun. It continued to decrease, while the patient's weight increased to 120 pounds.

In this case the emulsion was given without a vehicle. The patient at first complained of a sense of epigastric fullness and some nausea but later became accustomed to the emulsion and tolerated it well.

CASE 3: A 43-year-old white woman, after several years of treatment for menorrhagia, underwent hysterectomy and oophorectomy. Later gastric resection was done for chronic peptic ulcer. At the time of admittance for the latter operation the patient had been underweight for several weeks, and after the operation the weight decreased further. She was unable to eat more than a diet of 1,800 calories per day with 90 gm. of protein.

Fat emulsion was given, 2 ounces three times a day, at first in a milkshake between meals. This supplement caused a feeling of fullness so great that the patient had little appetite for the following meal, and it was therefore given immediately after meals. Later the fat emulsion was given without the milkshake. Ultimately it was well tolerated.

The patient's urinary nitrogen excretion decreased by 50 per cent during the period of observation. An increase of a few pounds in weight was maintained. Later the patient took a diet of 2,500 calories, supplemented by the fat emulsion, and made further gains in weight.

CASE 4: A 50-year-old white man was given fat emulsion supplement from the twelfth day after gastroenterostomy for duodenal ulcer with complete obstruction. The urinary nitrogen excretion decreased progressively while the body weight gradually increased. The patient tolerated the fat emulsion very well.

11 Middlefield Drive.

ACKNOWLEDGMENT

The author extends his thanks to Harold A. Harper, Ph.D., for advice and technical assistance in the studies here reported and to James J. McGinnis, M.D., Roy Pasqualetti, M.D., and James J. Raggio, M.D., for their cooperation in the treatment of patients.

REFERENCES

1. Forbes, E. B., and Swift, R. W.: Associative dynamic effects of protein, carbohydrate and fat, J. Nutrition, 27: 453, 1944.

2. Van Itallie, T. B., Logan, W. B., Smythe, R. L., Geyer, R. P., and Stare, F. J.: Fat emulsions for oral nutrition: IV, metabolic studies on human subjects, Metabolism, 1:80, 1952.

Electrocardiographic Changes Occurring with Trivalent Antimony Compounds During Therapy of Schistosomiasis

FRANCIS Y. K. LAU, M.D., *Oakland*

TWO PATIENTS with schistosomiasis japonicum recently treated with potassium antimony tartrate at Veterans Administration Hospital, San Francisco, had serial T-wave alterations similar to those seen in myocardial ischemia or myocarditis. Although they were closely observed no significant cardiovascular abnormality was noted in these patients during the course of therapy. As it was not known by the author that electrocardiographic changes of the kind noted may take place during administration of trivalent antimony compound, they were interpreted as indicative of serious disease. Since tropical diseases are not common in this area, the side effects and toxic reactions of specific therapy for these illnesses are not well known locally—a shortcoming that would seem to warrant a review of the studies

From the Medical Service, Veterans Administration Hospital, San Francisco 21.

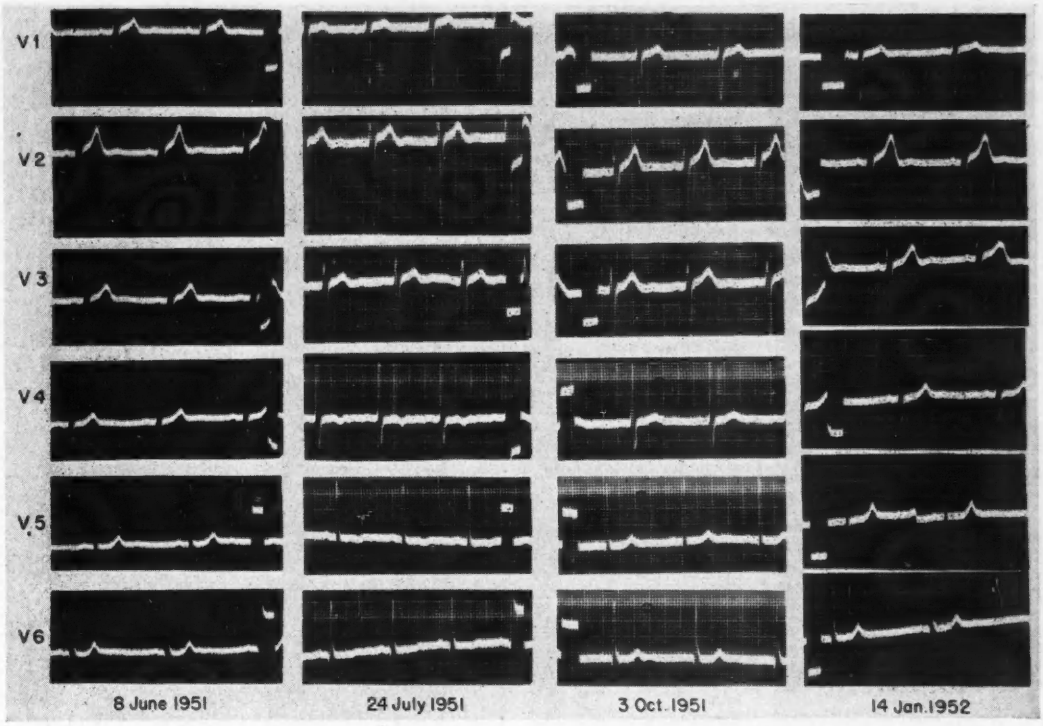


Figure 1.—Serial tracings of the precordial leads (Case 1) showed the most pronounced lowering and inversion on the thirty-third day of treatment, after the patient had received a cumulative total of 2 gm. of potassium antimony tartrate. Complete return of the T-waves to pretherapy status was noted on a tracing taken six months later.

done by Mainzer and Krause[1] and Tarr,[2] particularly since an increase in the incidence of such cases seems likely.

Before World War II the problem of schistosomiasis was distinctly foreign to the United States. Then about 1,500 known cases of schistosomiasis japonicum developed in United States military and civilian personnel who occupied Leyte. In addition, approximately 2,000 United States prisoners of war taken by the Japanese forces were quartered at Davao on Mindanao, a known focus of schistosomiasis. Only a dozen cases of schistosomiasis haematobium, and none of mansoni, occurred in American troops during World War II.[2] With extensive civilian travel and the presence of United States armed forces in endemic areas of the Orient and Near East an increasing number of cases is likely to appear.

Although thus far the majority of patients have been treated at Veterans Administration or military hospitals, it is probable that henceforth a number of cases will be diagnosed and the patients treated at other medical institutions.

Treatment with trivalent antimony compounds as outlined herein has not cured the disease in all cases. According to Most,[2] treatment failures with full courses of Fuadin® have been 50 to 80 per cent and with tartar emetic 15 to 25 per cent. Patients who have been treated may be asymptomatic for many years and then, upon recrudescence, be treated at other than governmental institutions.

Several specific factors probably contribute to the number of patients recently observed at Veterans Administration hospitals.

1. Natural course of the disease. The majority of the inadequately treated and the asymptomatic untreated patients may eventually have the late clinical manifestations such as unexplained emaciation, anemia, hepatomegaly, splenomegaly, pulmonary fibrosis, disorders of the nervous system, and urinary symptoms.

2. Stool survey. Dr. Harry Most supervised a study of specimens of stools of the armed services personnel who had been stationed in the endemic areas of the Far East at any time during World War II.

3. Diagnosis by rectal biopsy. During the late stages of the disease stools may be negative for ova but a rectal biopsy may be positive.

The electrocardiographic changes noted by Mainzer and Krause during treatment with the trivalent antimony compounds were T-wave alterations, prolonged Q-T intervals, P-wave changes, and bradycardia. Mainzer and Krause stated that in exceptional cases intoxication of the heart muscle might lead to heart failure and death, "probably through auricular fibrillation,"* but observations reported by Tarr and by Most do not agree with that view.

Tarr reported upon 141 patients followed with electrocardiograms (mainly standard leads) during therapy with tartar emetic or Fuadin. In the majority of cases, T-wave changes were the most prominent aberration; in 20 per cent of cases there were prolonged Q-T intervals; in only four cases were there negative or isoelectric P waves in leads 2

*In this quotation from the conclusion of the article written by Mainzer and Krause, the word *auricular* probably was used by mischance, since the authors spoke of *ventricular* fibrillation in the body of their article.

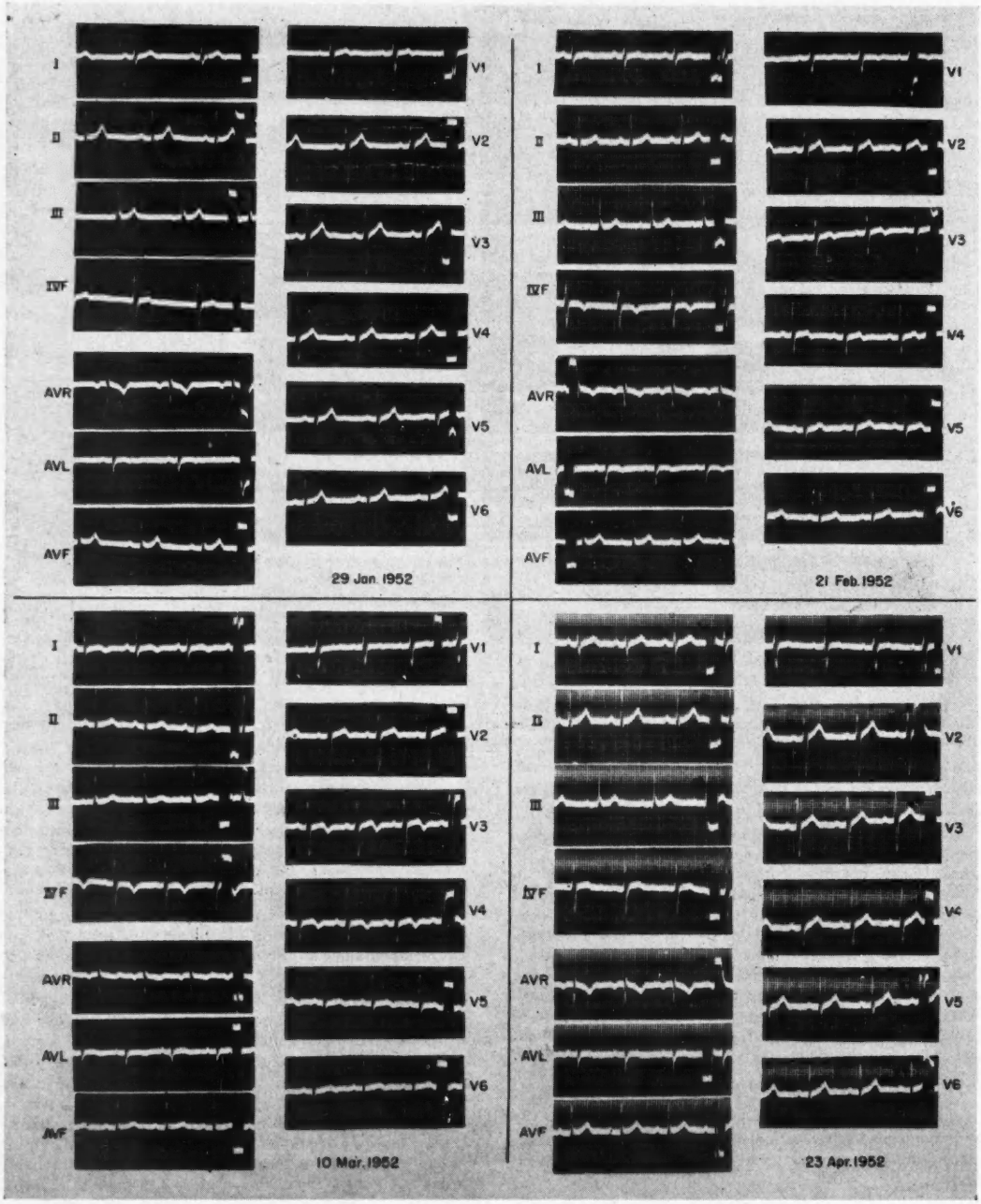


Figure 2.—Serial electrocardiograms showed changes of the T-waves in leads I, II, IVF, V_3 to V_6 after the patient had received a cumulative total of 0.44 gm. of potassium antimony tartrate. These changes were more pronounced 18 days later after the total amount of the drug had reached 1.80 gm. An electrocardiogram six weeks after cessation of therapy was the same as before therapy was begun.

and 3; bradycardia was not significant. These T-wave changes were noted sometimes in a single lead, but most often in more than one. In some cases there was only a decrease in amplitude, in others inversion. The T-wave alterations varied from person to person and were not necessarily an indication of the dosage or the speed of administration of the drug being given to the patient. It was reported that aberrations of the T-waves were more likely to occur when tartar emetic was given than when Fuadin was administered, owing to the greater amount of free antimony compound in the

former. Some of the patients observed by Tarr had a lowering of the T-waves when as little as 10 cc. of a 6 per cent solution of Fuadin was given, whereas in others there were no changes in T-waves at any time in a full course of treatment, regardless of which drug was used. In most of the cases the T-waves reverted to normal within six to twelve weeks after therapy was stopped. There were no deaths from cardiovascular abnormalities that could be attributed to antimony compound therapy.

CASE REPORTS

CASE 1. A man 30 years of age was referred in June, 1951, for treatment of asymptomatic schistosomiasis japonicum diagnosed by studies of fecal specimens. The patient had been a prisoner of war at Davao, Mindanao, during 1941-44. A bout of bloody mucoid diarrhea had occurred in 1943 and treatment with emetine had been given for two weeks. In 1946, following an episode of diarrhea, a private physician had treated him with "shots and tablets" for two months, presumably for amebiasis. The patient said he had not had diarrhea, constipation, melena or loss of weight recently.

The hemoglobin content of the blood was 15 gm. per 100 cc. Leukocytes numbered 8,600 per cu. mm.—51 per cent polymorphonuclear cells, 2 per cent stabs, 24 per cent lymphocytes and 13 per cent eosinophils. Eleven stool examinations were reported negative for ameba and Schistosoma. Three rectal biopsies also were negative. However, on the basis of the diagnosis on referral, treatment was begun.

The patient received injections of 0.5 per cent solution of potassium antimony tartrate on the following schedule:

Day	Cc.	Gm.
First	8	0.04
Third	12	0.06
Fifth	16	0.08
Seventh	20	0.10
Ninth	24	0.12
11th-47th (odd days only)	28	0.14
Total dosage		3.06

No untoward reactions occurred save for nausea and cough during injection of the solution. The pulse rate and blood pressure did not change following the injection. The patient did not complain of pain in the chest, shortness of breath or dizziness. Electrocardiographic changes were most pronounced on the thirty-third day of treatment when the cumulative amount of potassium antimony tartrate reached 2 gm. (see Figure 1). In an electrocardiogram made six months after cessation of therapy, T-waves were the same as they had been before treatment.

CASE 2. A 38-year-old man was referred in January 1952 for treatment of asymptomatic schistosomiasis japonicum diagnosed by studies of fecal specimens. The patient had been a prisoner of war in the Philippines and Japan from May 1942 to September 1945 but he did not remember any serious attacks of diarrhea, abdominal pain, skin eruption or fever. Upon physical examination no abnormalities were noted and the patient appeared to be in excellent health.

The hemoglobin content of the blood was 14.6 gm. per 100 cc. Leukocytes numbered 6,550 per cu. mm.—49 per cent polymorphonuclear cells, 1 per cent banded forms, 43 per cent lymphocytes, 3 per cent monocytes and 4 per cent eosinophils. Thirteen fecal specimens were examined for ova and parasites. Although ova of hookworm and T. trichiuris were observed, none of Schistosoma japonicum were present. Tubercle formation and ova compatible with schistosomiasis were noted in biopsy of rectal tissue.

The patient received injections of 0.5 per cent solution of potassium antimony tartrate on a schedule similar to that followed in Case 1. The only symptom noted during the administration of potassium antimony tartrate was a brassy cough. There was no change in the pulse rate or blood pressure. The patient did not complain of pain in the chest, shortness of breath, palpitation, or swelling of the ankles. The electrocardiographic changes were most pronounced when the patient had received a cumulative total of 1.8 gm. of potassium antimony tartrate (see Figure 2). Six weeks later no abnormalities were noted upon physical examination, and x-ray films of the chest, an electrocardiogram and a ballistocardiogram were all within normal limits.

COMMENTS

The T-wave alterations in the two cases herein reported occurred without significant changes in the QRS complexes, Q-T intervals, P-waves, and S-T segments. The patient in Case 1 had bradycardia before and throughout therapy. Although the T-wave changes in both cases strongly suggested the possibilities of (1) coronary artery insufficiency, (2) pericarditis, (3) myocarditis, toxic or inflammatory, there were no clinical or laboratory findings to support diagnosis of any of those conditions in either case. Furthermore, all the T-waves reverted to pre-therapy status within the time required for antimony excretion.

SUMMARY

Two patients with schistosomiasis were treated with potassium antimony tartrate, and serial electrocardiograms showed alteration of T-waves during therapy. There were no clinical or laboratory data to indicate that the T-wave aberrations might be caused by cardiovascular disease. After therapy was discontinued, electrocardiograms returned to normal.

Thirteenth and Harrison Streets.

REFERENCES

1. Mainzer, F., and Krause, M.: Changes of the electrocardiogram appearing during antimony treatment, Trans. Roy. Soc. Trop. Med. & Hyg., 33:405, Jan. 1940.

2. Most, H.: Schistosomiasis in the veteran, Vet. Admin. Tech. Bull., TB 10-36, 26 Sept. 1947.

3. Tarr, L.: The effect of the antimony compounds, Fuadin and tartar emetic on the electrocardiogram of man, a study of the changes in 141 patients treated for schistosomiasis, Ann. Int. Med., 27:970-988, 1947.

California MEDICINE

DWIGHT L. WILBUR, M.D. . . . . Editor
ROBERT F. EDWARDS . . . Assistant to the Editor

Editorial Executive Committee:
ALBERT J. SCHOLL, M.D. . . . . Los Angeles
H. J. TEMPLETON, M.D. . . . . Oakland
EDGAR WAYBURN, M.D. . . . . San Francisco

For information on preparation of manuscript, see advertising page 2

EDITORIAL

Unlawful Practice

PHYSICIANS IN CALIFORNIA have wondered for years why certain actions by unlicensed persons, which in their opinion constitute the unlawful practice of medicine, are not stopped. They often see various treatments and "cures" offered by persons whose training is at best dubious, and sometimes they are appalled by more grandiose medical care schemes established and operated by others than licensed physicians. Why can't this sort of thing be nipped in the bud and a fraud on the public prevented?

The answer, of course, lies in the legal statutes of the state and their interpretation by the courts.

The practice of medicine is defined in the Business and Professions Code of California and is limited in that code to those who are regularly licensed under other sections of the same body of law. Those who attempt to practice medicine without coming under the provisions of the Business and Professions Code are in actual violation of the law.

Such violations often come about when a person who is licensed to practice only a profession bearing faintest kinship to medicine attempts to work beyond the legal boundaries set up under the form of license he holds. And sometimes persons with no claim to training or licensure of any type, possibly professing to have "an old Indian secret," undertake —for a fee, of course—to treat human ailments.

More recently, violations of the medical practice act have come about through corporations which hold themselves out to the public as providing a medical care service through a closed panel of physicians who are regularly licensed. This form of corporate endeavor has been before the California courts on several occasions and the courts have consistently held that medicine, like lwa, may be legally practiced only by those who are regularly licensed. Several insurance companies have run afoul of this provision over the past twenty years and have been forced to discontinue supplying the services of a physician through an insurance policy.

A corporation transgressing the medical practice laws generally comes under the purview of one or another department of the state government and is brought to book by that department. On the other hand, an individual, licensed or not, may not be prosecuted unless the district attorney agrees to press the case. As might be expected, many district attorneys have passed over violations which to medical men are obvious but which, in the legal eye, may present undue difficulty of proof or may at the most constitute a nuisance of the misdemeanor variety.

New possibilities for prosecuting alleged violations of the medical practice act will be opened up next month, when a law passed by the 1953 State Legislature goes into effect. This law provides that ten or more licentiates of the Board of Medical Examiners may seek a court injunction to investigate and prohibit the unlawful practice of medicine. Superseding a local court decision which held that the right to seek injunctive relief lay only in the hands of the Board of Medical Examiners, this new law permits a group of physicians, acting under adequate legal safeguards to the accused, to bring injunction proceedings where, in their opinion, the practice of medicine is being undertaken illegally.

Now, for the first time, the medical profession will not be completely dependent on the examining board or on district attorneys to seek to abate unlawful practice. In cases where the elected or appointed officials are too busy or are for other reason reluctant to eliminate nefarious practices, a group of physicians may step into the picture and seek court relief.

The California Medical Association has been quick to provide for the use of this legal remedy. The Council has appointed a Committee on the Un-

lawful Practice of Medicine, a committee of 17 members which is charged with cooperating with other agencies to secure compliance with the medical practice laws. This committee is authorized to confer with public officials, to seek out and attempt to prohibit the unlawful practice of medicine and to use all available means of consultation, cooperation and persuasion in stopping those acts which are considered to be unlawful practice.

Failing in such endeavors, the committee is authorized to seek legal injunctions against such alleged illegal practices and to follow up with court action. The committee has been made adequately large to comply with the requirements of the new law and properly representative of both the official C.M.A. family and the geographical and population factors of California. It reports directly to the C.M.A. Council and will operate under the guidance and authority of that body.

The legal profession has had such committees for a number of years and has found them to be singularly effective in stopping the illegal practice of law. Now medicine has the same opportunity.

Here at last is the chance for medicine to put a stop to various forms of illegal medical practice, in cooperation with those public agencies which have previously been authorized to seek such legal relief. Here is the opportunity to deal cooperatively with public agencies, with the prerogative of taking further legal steps if such agencies do not agree to go to court in particular instances.

This committee is not expected to perform spectacular feats. It is not expected to revolutionize any existing conditions or seek to inflict unusual punishment on those who may be violating the medical practice laws. Rather, it is expected to bring about an orderly compliance with the laws of the state and to exert its influence by access to courts where lesser measures fail. Its results should provide better safeguards, in the public interest, against illegal medical practices which may encompass fraud, misrepresentation and quackery.

Trouble in Paradise?

MR. JOSEPH T. DESILVA, a man who confesses to many talents and who is at present the executive secretary of the Los Angeles Retail Clerks Union Local 770, will probably be the least surprised of all our readers to find himself the author of this "Guest Editorial."

Writing in *The Voice of 770,* Mr. DeSilva makes some valuable contributions to the history of panel practice plans. His remarks should be of more than passing interest to any employee group contemplating the purchase of a health plan. Physicians can be of assistance by calling Mr. DeSilva's words to the attention of persons contemplating the interruption of the personal patient-physician relationship and thereby becoming captives in a panel scheme.

Step in, Mr. DeSilva:

"Because of the transition from the initial Permanente operations to the expanded services in conjunction with the new hospital, we are very well aware that some inconveniences have occurred. For instance, the long waiting period for appointments—a problem which is now being reduced systematically. Another, the waiting period for elective surgery (when a person chooses to have surgery performed when it could wait). The inadequacy of the house call procedure. The strain under which the doctors have been working. The hastily put together nonprofessional staff.

"At each week's meeting between Permanente and executive office personnel of the Union, these problems are being ironed out. We will eventually be 'on top' of the situation, anticipating the problems rather than settling crises.

"PLAN ABUSED

"While we have now slapped ourselves on the wrist, all of the problems are not due entirely to Permanente failure to predict the future nor the Union's short vision. At least a substantial part of the blame is caused by the many members who abuse the plan. Their impatience causes friction. They request house calls for ordinary matters which could be handled by themselves. They possess no regard for time and engage in lengthy telephone conversations explaining to the nurse all the facts that should be told to the doctor, tying up the switchboard for other calls which may very well be emergencies. They make appointments and do not show.

"The 'no shows' are the worst. Others lose out because the doctor and nurse have turned down other appointments to reserve their time for a person who turns out to be a 'no show.'

"CONSTRUCTIVE CRITICISM

"Because it is the popular thing to do, the easiest way to get out of any situation, we have fallen into the same groove of the national and world pattern of building hatred through criticism in order to hide our own shortcomings. So if criticism must be

done, let it be in the form of constructive suggestions.

"But we have painted a dark picture. All is not as black as pictured, for each day the situation grows brighter. Nothing is being neglected; everything that can be done is being done to make your health plan a joy for every member.

"Are you one of the lucky ones who did not have to call a doctor? We hope you stay that lucky."

Since Mr. DeSilva is our guest we must, perforce, refrain from drawing any conclusions from his dissertation on the travails of a union agent attempting to invade the field of medicine. Courtesy indicates we say only:

"We, too, hope you stay *that lucky* — Mr. DeSilva."

[Reprints of the above in circular form are available in any quantity to C.M.A. members. Requests should be directed to the *Public Relations Department*, CALIFORNIA MEDICAL ASSOCIATION, 450 Sutter, San Francisco]

LETTERS to the Editor . . .

Hand Talking Chart

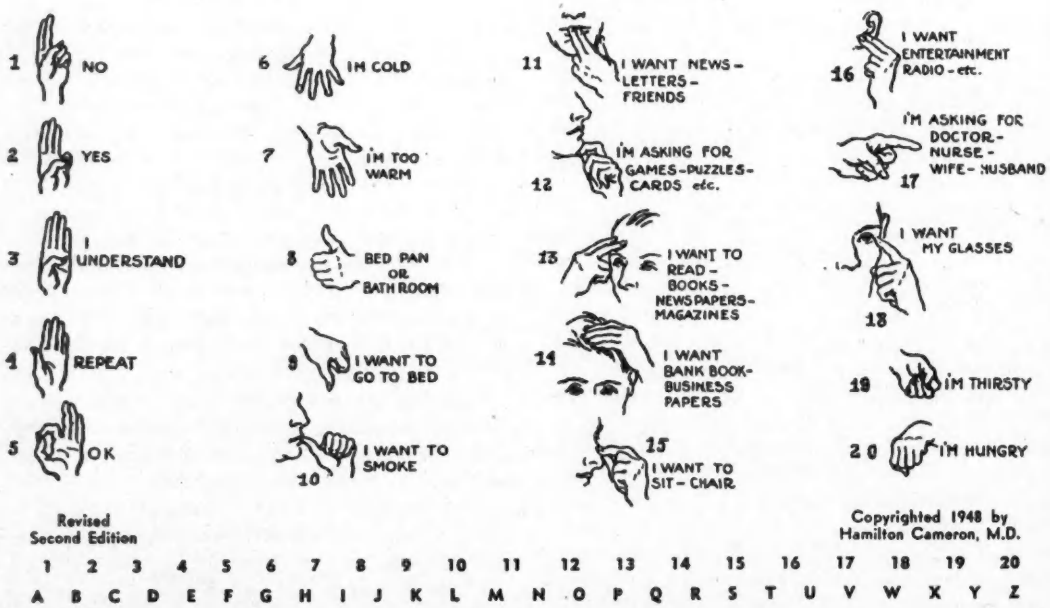
April 20, 1953

WHILE in a right hemiplegic complete aphasic condition, I evolved the "Hand Talking Chart." I have been distributing the chart with the cooperation of the editors of medical publications. It is estimated there are 400,000 aphasic persons in this country. Readers may have copies of the chart, gratis.

Sincerely yours,

HAMILTON CAMERON

601 West 110th Street
New York 25, N. Y.



HAND TALKING CHART. The sign language in the designs speaks for itself. The figures and letters across the bottom are independent of the designs. By pointing with pencil or finger to the letters or figures needed to further a conversation, communication between patient and friend can be amplified even to the "dictation" of a letter by the patient who otherwise would remain completely inarticulate.

California MEDICAL ASSOCIATION

NOTICES & REPORTS

C. M. A. House of Delegates Proceedings

Los Angeles, May 24-28, 1953

Sunday Morning Session

The Eighty-second Annual Session of the California Medical Association convened in the Renaissance Room of the Biltmore Hotel, Los Angeles, California, Sunday, May 24, 1953, at 9:50 o'clock a.m. The meeting was called to order by Speaker Donald A. Charnock, who presided.

SPEAKER CHARNOCK: Will the House of Delegates of the Eighty-second Annual Session of the California Medical Association please be in order.

The first order of business is the report of the Committee on Credentials and Organization of the House of Delegates, Dr. Hoffman.

DR. HOFFMAN: Mr. Speaker, a quorum is seated.

As chairman of your committee, I move that the visual roll call as seen at the entrance of this room be accepted as the roll call for this Sunday's session.

SPEAKER CHARNOCK: Is there a second to that?

DR. DONALD CASS: I second the motion.

... The motion was put to a vote and it was carried ...

SPEAKER CHARNOCK: We are in session.

I first want to announce the committees.

Credentials Committee: Eugene Hoffman, Los Angeles, chairman; Louis P. Armanino, San Joaquin; Joseph W. Telford, San Diego.

Reference Committee No. 1—Reports of Officers, the Council and Standing and Special Committees: J. W. Moore, Ventura, chairman; James B. Graeser, Alameda; Ralph Teall, Sacramento.

Reference Committee No. 2—Reports of the Secretary, Treasurer, and Executive Secretary, Consideration of the 1953-54 budget, and 1954 annual dues: Robertson Ward, San Francisco, chairman; John E. Vaughan, Kern; Thomas P. Hill, Mendocino.

Reference Committee No. 3 — Resolutions and New Business, exclusive of Amendments to the Constitution and By-Laws: E. C. Rosenow, Jr., Los Angeles, chairman; Helen B. Weyrauch, San Francisco; Carl M. Hadley, San Bernardino.

Reference Committee No. 4—Amendments to the Constitution and By-Laws: Albert G. Miller, San Mateo, chairman; Thomas A. LeValley, Los Angeles; Dorothy Allen, Alameda.

C.P.S. Reference Committee, Resolutions, et cetera, relative to California Physicians' Service: Thomas N. Foster, Santa Clara County, Santa Clara, chairman; A. Norman Donaldson, Orange; Paul D. Foster, Los Angeles.

If there is no objection from the House, these reference committees will stand as read.

Hearing no objection, they are as read.

The next order of business is an address by our President, Lewis A. Alesen. (Standing applause.)

DR. ALESEN: Mr. Speaker, Members of the House of Delegates: The most important, the most efficient speech ever made was, "I thank you."

We shall now proceed to the awarding of the 50-Year Pins.

PRESENTATION OF 50-YEAR AWARDS

DR. ALESEN: We have a number of distinguished physicians whose names we shall call. If they are in the house will they please come forward for these awards: Dr. Clark L. Abbott, Alameda County; Dr. Margaret W. Kaiser; Dr. Robert T. Legge; Dr. Arthur M. McIntosh; Dr. George G. Reinle; Dr. George W. Sweetzer; Dr. Clemence A. Wills, Los Angeles County.

These physicians, as their names are called, please come up to the platform: From Los Angeles County, Dr. Edmund M. Lazar; Dr. Edwin O. Palmer, from Sacramento County; Dr. E. M. Wilder, from San Francisco County; Dr. Herbert W. Allen; Dr. George W. Ebright; Dr. Arthur L. Fisher; Dr. Charles E. French, from San Francisco County; Dr. A. S. Caner; Dr. George J. McChesney; Dr. William G. Moore; Dr. Silvio J. Onesty; Dr. Herman F. Wilson; Dr. Emma K. Bullits; Dr. Frank H. Zumwalt, from Santa Barbara County; Dr. Benjamin Bakewell.

Ladies and gentlemen of the House of Delegates, it is a pleasure indeed to have this opportunity to present these pins which you are giving these distinguished gentlemen and ladies of medicine for fifty years' service. (Applause.)

I wonder, ladies and gentlemen of the House of Delegates, if you wouldn't like to hear just a brief word from each of these gentlemen whom we have honored.

Dr. Reinle, who is a Past President of the California Medical Association.

DR. REINLE: Well, as I stepped on that platform, I said, "It is a hell of a long time." But, nevertheless, I can say this, probably for those that are with us, that it has been a very wonderful time to practice medicine for fifty years, and still be alive. Thank you. (Applause.)

PRESIDENT ALESEN: Anybody who has been at the University of California will, of course, know Dr. Legge.

Will you give us a word, Dr. Legge?

DR. LEGGE: Members of the House of Delegates, Mr. President: It is a great pleasure to be here today to receive this token. It seems to me that the fifty years I have been a member have passed very rapidly. So I have attained my majority.

I want to thank you all for this token. (Applause.)

PRESIDENT ALESEN: Dr. Edward O. Palmer, known as the Dean of Hollywood. Dr. Palmer.

DR. PALMER: Mr. Chairman, gentlemen: I feel greatly honored to be recognized among you. It is true I have been a member of this organization for fifty years. I was a member of the American Medical Association in New York City for eight years before that. So, I have been honored for years with the support of my associates in my practice of medicine.

I thank you very much for this. (Applause.)

PRESIDENT ALESEN: Of course, Dr. Caner is one of the maestros of San Francisco. Dr. A. S. Caner.

DR. CANER: Ladies and gentlemen: I thank the Society for the honor they have given me today, for having served fifty years—over, fifty-four in my case, as an active member of the California Medical Association. I thank the good Lord for giving me health and strength to live that long. Thank you. (Applause.)

SPEAKER CHARNOCK: I am sure we have all been very much inspired by the appearance of these gentlemen today.

As you are all aware, resolutions should be presented in triplicate. Stenographic services are available in Room 1344.

At this time, we will have the reports of the officers and of the special committees.

We have made a little different arrangement this year, and only those officers and special committees who actually have an additional report to make will be called upon. If any of these officers and special committees feel that they have an additional report at the completion of this collection of reports, we will be happy to let them make their report.

The first will be Dr. Sidney Shipman, Chairman of the Council.

REPORT OF THE COUNCIL

DR. SHIPMAN: Mr. Speaker and members of the House: As you know, the Council met all day yesterday and considered a number of things. I will not detail the procedure at the Council yesterday, except to say that there will be several resolutions which will be introduced on behalf of the Council when the proper time comes.

There is one matter, however, which I would like to have you acquainted with, which was dealt with by Dr. Alesen as chairman of the committee to deal with the matter of Blue Shield and Blue Cross in the southern part of the state.

With your permission, Mr. Speaker, I would like to ask Dr. Alesen to give a report of that matter to the House. Is that permissible?

SPEAKER CHARNOCK: Yes, sir.

Dr. Alesen, will you give the report?

REPORT OF THE SPECIAL COMMITTEE ON BLUE SHIELD-BLUE CROSS

DR. ALESEN: Mr. Speaker, and ladies and gentlemen of the House: By action of the Council of the California Medical Association, on February 22 a special committee was appointed by the chairman to seek close cooperation between the three professionally sponsored prepayment plans in the State of California. This consisted of Dr. Ben Frees, Mr. R. E. Heerman, Mr. George Bodenhausen, and myself as chairman.

We immediately called a meeting of the board of directors of the Hospital Service of Southern California and California Physicians' Service on March

5. At that time, almost without exception, the two boards of directors were present.

We had an excellent exploratory meeting at that time, and it was decided to set up a joint committee and to invite the members of the Blue Cross of Northern California, the Hospital Service of California, to participate in our deliberations, and so a more or less permanent committee was formed with three members from each of the three prepayment plans, with L. A. Alesen as chairman, and with the attorneys of the three plans acting as legal counsel.

Now, these committees have had two special meetings. We met once in Los Angeles on April 3, and once in San Francisco on May 8.

At first, bringing together the representatives of these plans, there was noticed a certain degree of skepticism. Inquiries were made as to just what the California Medical Association expected to accomplish, what were its purposes, and did this special committee in fact have the approval and the authority of the California Medical Association to proceed.

However, we very soon convinced these gentlemen that we did mean business very seriously, and that our one objective was to seek and to obtain the very closest possible cooperation between the sponsors of the three professional prepayment plans in California, for just one purpose; and that is in order that we might more effectively render to the people of this state good, prepayment medical care on a basis which would be sound, which would be competitive and which, most of all, would help us to meet the ever-present blandishments of the socializer.

Now, those are the plain facts of life as they were discussed.

At the last meeting held in the St. Francis Hotel in San Francisco on May 8, we worked until about 1:45 a.m. We discussed the various possible ways of cooperation from joint operating agreements on through to a final condition of a statewide joint corporation held by representatives selected by the medical profession, representatives selected by the hospital profession, and representatives selected by the public at large.

A special resolution was then prepared by Mr. George U. Wood of Hospital Service of California. Mr. Hoffman and Mr. Heerman stated in substance that it is the consensus of our special committee that ultimately and as soon as possible, a single, joint corporation should be formed to take over the functions of the three special existing plans. In the meantime, it was indicated that every step should be made to insure a closer cooperation in the sales force, the provisions of contracts, and in every manner to present to the public of California the fact that we and the hospital professions are in fact interested in efficient operation, and no longer want to squabble among ourselves.

Now, our committee presented a resolution to the Council this morning which was approved and which Dr. Shipman is going to present to you.

As the chairman of this special committee, I would like to say just one personal word. It is my opinion that today a great deal of progress toward our common goal has been made. I believe the petty differences, the personality clashes, the small, private vested interests that have been roadblocks to such an achievement in the past are gradually dissolving when these men of good will have gotten together around the council table and have found their opposition in the other organizations do not, in fact, wear horns.

I believe we can accomplish something worth while.

So, ladies and gentlemen of the House of Delegates, I think in the future, and I hope in the very near future, our legal department will be able to report to you that we have achieved something very solid, very fundamental.

SPEAKER CHARNOCK: Thank you, Dr. Alesen. That report will be referred to Committee No. 1. Next will be a report on C.P.S. Dr. Cass!

REPORT OF CALIFORNIA PHYSICIANS' SERVICE

DR. CASS: Mr. Chairman, Delegates, members of the C.M.A. House of Delegates: It is with pleasure and pride that I today report to you on the operations of the California Physicians' Service, and suggest the areas in which this plan can be of greatest service to the people of California and to the medical profession.

The six years I have served on the Board of Trustees have been years of continuous change in the field of financing the cost of accidents and sickness. During this period C.P.S. has continuously and rapidly grown. Most of the problems of the recent past were an outgrowth of this rapid expansion.

The Trustees of C.P.S. now look forward with confidence to a period of increased and broadened service to the public, beneficiary members and to its member physicians, and it is believed that members of the medical profession may share this confidence.

Careful estimates indicate that the membership of C.P.S. will increase during the next 12 months by more than 50,000; the number of physician members has increased during the past year and it is expected that it will continue to increase for the next year; services and benefits are being increased in certain areas of coverage; fees may be adjusted upward; and C.P.S. will continue to be the largest of the non-profit prepaid care plans in this state.

It is expected that C.P.S. will be an increasingly potent force in this field of prepaid care and will render the type and character of service of which any doctor might well be proud.

Physician Relations:

The number of doctor members continues to increase . . . and the cooperative attitude of doctors is gratifyingly improved. Doctors in various sections of the state are recommending C.P.S. membership to patients. Other doctors are volunteering to speak at meetings in behalf of C.P.S.; and the

attitude of the medical profession as expressed in letters, phone calls and personal contacts indicates an improved friendly attitude of helpful cooperation.

During the past year the experimental decentralized plan of beneficiary member and doctor contact in Santa Clara County has been expanded. Plans are now under way to broaden this method of service to each county of the state.

In other sections of California the plan whereby a C.P.S. representative notifies, by letter, telephone or personal contact, those patients whose claims are rejected for cause, has been extended, and doctors express approval in being relieved of the necessity of notifying patients of claims rejected by C.P.S.

The plan of notifying patients that their medical, surgical and hospital bills have been paid to doctors and others has likewise been extended to various sections of the state and this program has received favorable comment from doctors and patients alike.

At this time I wish to thank the Delegates of this House, the members of the C.M.A. Council, the members of Reference Committee No. 1, the members of the C.M.A.-C.P.S. Study Committee, the members of the Medical Services Commission, as well as the officers and members of the county societies for their patience and understanding during this period of adjustment. The expression of continued confidence has been heartening to the Trustees and has made possible the establishing of a foundation on which the future growth in service may be built.

Plan of Indemnity Coverage with Controlled Costs:

Members of this House will recall the recommendations of the C.M.A. Study Committee and the action of the delegates in connection with the proposed program of indemnity coverage with costs controlled under state, county and individual fee schedules.

The testing of this plan was left to the county societies and C.P.S. Many of the county societies have polled their members; others have developed programs leading to a consideration of the plan; but so far as is known, no county has as yet agreed on a county fee schedule.

The Trustees of C.P.S. authorized the formation of an indemnity insurance company, and articles of incorporation have been filed. Upon receipt of a request from one or more county societies, C.P.S. is prepared to develop contracts to fit county conditions, and to take such other steps necessary to give this proposed program a thorough test.

Blue Shield-Blue Cross Relations:

California: You will perhaps recall that the C.M.A.-C.P.S. Study Committee suggested to the C.M.A. Council that steps be taken to bring about a new working arrangement between the two Blue Cross plans and C.P.S. in California.

Dr. Lewis Alesen was appointed chairman of a committee to explore possibilities and make recommendations. Dr. Alesen called a meeting of the Trustees of Southern Blue Cross and C.P.S. This group approved in principle the desirability of a close working arrangement between the two plans.

A special committee of three trustees from each Blue Cross plan, together with three members of C.P.S. Board of Trustees, the attorneys and the executive directors of each plan, headed by Dr. Alesen as chairman, was formed. This committee held a number of meetings for the purpose of discussing ways and means to accomplish the desired results.

In the meantime, the dissolution of joint service contracts in Southern California has proceeded under a resolution adopted by the board of directors of the Southern Blue Cross, and the loss in members in C.P.S. in Southern California is largely a result of this dissolution. It is expected that the remaining joint contracts in Southern California will be dissolved before March 31, 1954.

National: It may be of interest to the delegates to know that the National Blue Shield Commission and the National Blue Cross Commission have recently signed an agreement whereby national accounts will be sold jointly and that these accounts will be serviced by Blue Shield and by Blue Cross in the different states.

By national accounts, of course, I mean those accounts such as interstate operators, General Motors, big companies like that. Through the national organizations, it will be sold and then distributed to the Blue Cross through Blue Shield plans in each state. That took a long time and a lot of work to get the two organizations to agree on details, but it has finally all been arranged.

With the increasing demand on the part of employers with plants and branches in different sections of the country—and of unions, especially industry-wide unions such as C.I.O.—demanding uniform coverage and nationwide benefits (with rates adjusted to the needs of each area) the demand for nationwide contracts is becoming more and more insistent.

If the doctor-sponsored and hospital-sponsored non-profit plans are to secure their rightful proportion of this coverage, then these two plans, working together, must develop a working arrangement at state level that will permit the rendering of uniform type of service nation-wide.

It is believed that Dr. Alesen's committee will lay the foundation for furnishing cooperative service to these national accounts.

Financial Status of C.P.S.:

C.P.S. continues in a sound financial condition. Payments made to doctors and hospitals, together with reserves necessary to protect these payments, represent 85½ cents out of each dollar received from members' dues.

Administrative expense, including cost of acquisition of new members, was 14.5 per cent of total dues income.

The stabilization reserves of C.P.S. on March 31, 1953, equaled $9.56 per beneficiary member. The minimum reserves of private insurance companies are set by law, but no one has as yet determined the

minimum reserve necessary in voluntary health plans. The rapid growth of all Blue Shield and Blue Cross plans has taken place in an era of expanding economy and inflation. No plan has yet been operated in a depression, with increasing unemployment and other deflationary conditions.

The businessmen members of the board now feel that C.P.S. reserves have reached a total that will permit some increase in fees and some reduction in the rates of certain contracts. The trustees recently appointed a C.P.S. Fee Schedule Committee to study, with the Finance Committee and the Medical Services Commission, the possibilities of such a program.

At this time I wish to personally thank the business men on our board who have contributed so generously of their time, energy and ability toward making California Physicians' Service a sound and substantial operation. Their services are deeply appreciated by the other trustees and I trust by the medical profession of California.

The financial condition of C.P.S. as of the end of the fiscal year, March 31, is reflected in the financial statement available to those interested.

Responsibility and authority for the management of California Physicians' Service rests with the Board of Trustees. This board consists of fourteen representatives of the medical profession. Eleven of these members serve for a period of three years, and may be reelected for one term of three years, with six years as the maximum period any member of this group may serve consecutively.

Three doctor members are appointed each year by the C.M.A. Council to serve for one year. These members may be reappointed each year as the Council may decide.

In addition to the doctor members, there are four lay members who also are elected for a term of three years, but lay members may be reelected for more than one term.

You will perhaps recall that upon recommendation of the Study Committee, the C.M.A. Council has now become the Nominating Committee for C.P.S. Trustees, and you will have the privilege of voting on the nominees for the coming three years at this Annual Meeting. Nominations may also be made from the floor of the House of Delegates at the time designated.

The members of the Board of Trustees of C.P.S. elect their own officers.

A number of operating committees are appointed each year and advise the trustees on matters relating to contracts, finance, medical policy, et cetera.

Recently a number of changes have taken place in the administrative management of C.P.S. and a step-by-step reorganization is now taking place under a plan developed several months ago. The trustees are determined to make C.P.S. the best managed voluntary health plan possible, and everything is being done toward that end.

Growth Possibilities of C.P.S.:

In California today C.P.S. has enrolled as beneficiary members approximately six and one-half per cent of the total population. The two Blue Cross plans and C.P.S. cover perhaps seventeen and one-half per cent of all of the people of the state.

The two Blue Cross plans and C.P.S. cover approximately 1,750,000 people in a state with a population of 10,000,000. In Michigan, Blue Cross and Blue Shield cover 2,750,000 people in a state with a population of 7,000,000.

The statement was recently made by a speaker in the East to the effect that the medical profession was best protected from the threat of socialized medicine if voluntary coverage was widespread among many insurance companies, non-profit plans and others, rather than to permit the development of a single plan that might become a near monopoly.

It is now the opinion of most leaders in the medical profession in California that C.P.S.-Blue Shield should be a strong plan serving a sizable number of members, but working with other plans and groups wherever practical.

Most groups interested in C.P.S. coverage are small in number. The leaders of large groups, whether employer or labor leader, contend that the C.P.S. income ceiling is today unrealistic, and that very few of the members of the group have incomes under the ceiling; and thus the present C.P.S. service plan becomes in fact an indemnity program so far as a large proportion of members whose incomes are now over the income ceiling are concerned.

The raising of the schedule of fees paid to doctors and the raising of the income ceiling would permit C.P.S. to enroll larger groups, as contracts would then be more nearly competitive.

The Future of C.P.S.:

Voluntary prepaid medical, surgical and hospital insurance in some form, whether provided by non-profit plans or private insurance companies, is now a part of the American way of life. Voluntary non-profit plans now have enrolled more than 40,000,000 persons in the United States. A committee of the State Chamber of Commerce estimates that 50 per cent of the population of California is now covered by some form of prepaid health insurance.

Most people realize that prepaid health insurance is still in its formative "trial and error" stage. The contracts or policies of most insurors are still subject to change, still being tried, tested and adjusted.

Those who have made a study in this field estimate that within the next five years 90 per cent of those employed will be covered by some form of health insurance paid for by the employer. Many unions are already bargaining for the payment by the employer of the cost of prepaid care for dependents as well.

It is believed that a non-profit organization such as C.P.S., controlled and directed by doctors, can best maintain a balance in this field and make unnecessary the fixing of fees by a department of the state as has recently been proposed in the case of workmen's compensation.

The Trustees of C.P.S. are determined to follow a program of increased benefits to beneficiary members, adjusted fees for doctors, competitive rates on coverage, closer contact and improved service to doctors, all to the end that both the public and the doctors may be better served in the financing of the cost of accident and sickness.

Moreover, a strong progressive C.P.S. is the logical instrument to express the medical profession's conviction that the basic principles of voluntary, prepaid health care on a service basis provide (1) medical direction and control, and (2) free choice of doctor.

Throughout this area, as you all know, there is a rising challenge to these basic principles from a type of closed panel plan that provides neither this free choice of doctor nor medical control. Instead it provides (under lay management) captive doctors and captive patients; the plan even encourages the outright solicitation of patients away from their own personal physicians.

As free physicians, with a duty to the public and to medicine, we can best express our convictions by our wholehearted support of medically-sponsored C.P.S.

The Study Committee, in its report to the interim meeting of the House of Delegates in December 1952, restated the objective of C.P.S. The Trustees, in their action, have caused many changes to be made in the coverage, scope of operations and management of C.P.S., and it is believed that the doctors today can point with pride to the progress that has been made in this California Blue Shield plan, without overlooking or forgetting that the road ahead is still steep, rocky and long.

Thank you, gentlemen, for your attention to the last report of this President of California Physicians' Service. (Applause.)

SPEAKER CHARNOCK: Thank you, Dr. Cass.

We will next hear from Mr. K. L. Hamman, the Executive Vice-President of California Physicians' Service. Mr. Hamman!

MR. K. L. HAMMAN (Oakland): Mr. Speaker, members of the House of Delegates: I have been asked to supplement the remarks of Dr. Cass, especially as they relate to the financial condition of the California Physicians' Service.

During the past two and a half years, under a program adopted in Southern California, there has been a dissolution of contracts held in Southern California.

Unfortunately, as a result of that dissolution, there has been spread abroad by competing salesmen or others, the claim that C.P.S. was not financially strong.

I should like to report to you in detail, therefore, as to the financial condition of C.P.S., without quoting too many figures.

In the year just ended—the financial year of C.P.S. ends on March 31—the total income of C.P.S. from dues from beneficiary members was $21,911,219.14. The income of the Blue Cross plan in Southern California was $17,406,915.65. The income of the Blue Cross in Northern California was $14,053,372.10.

The total of all three non-profit plans, therefore, was approximately $52,000,000.

The question of administrative expenses is always paramount in the operation of any plan of this type. Your large holders of group membership such as the Standard Oil Company or the California State Employees, or others, want to know how much it costs to administer the plan, how much service the member receives on the average.

Dr. Cass has reported to you that in the C.P.S. operation this past year, eighty-five and a half cents out of every income dollar from dues went to doctors, hospitals, or to the reserves to protect those payments.

That means that the cost of administration, the acquiring of new members, and the other expenses of operation amounted to 14.5 per cent.

The year before it was 15.14 per cent, and the budget as now approved for this coming year, beginning April 1, will again be 14.5 per cent.

During the period of operation of the last few years, C.P.S. has acquired cash reserves to protect the payment to both doctors and hospitals. And as Dr. Cass also stated in his report, the size of a reserve for a non-profit plan of this type has never been determined. The reserves for an insurance company are set. The minimum reserves are set by law; in a plan of this type, however, there is no such requirement, except in the case of Blue Cross plans and that is relatively small.

However, those who have studied the operation of Blue Shield and Blue Cross plans nationwide have hit upon a horseback rule which is the best that anyone yet has, for no plan has yet been subjected to the trials and tribulations that would come with a depression, or even a minor recession. No plan has yet been confronted with the problem of widespread unemployment, and, therefore, loss of income, especially that income paid for on the part of the employee.

This horseback rule is that a plan should have a reserve of equal to at least three months' service cost, medical and hospital, and a maximum of six months.

It may interest you to know what the reserves of the two Blue Cross plans and C.P.S. are in relation to that particular yardstick. The Blue Cross in Southern California has a reserve of equalling 1.15 months. In other words, about one and one-sixth of a month. The Blue Cross in Northern California has a reserve of equalling the service costs of 2.95, or almost three months. C.P.S. has a reserve of 3.26, or three and a quarter months of total dues.

None of these plans anywhere near approaches what was supposed to be the maximum reserve to be carried, but the Northern Blue Cross and C.P.S. have at least a reserve in relation to the minimum.

Expressed in another way, Mr. Linder, representing an eastern firm of actuaries, made a report to the C.M.A.-C.P.S. Study Committee last year in which he stated that the Blue Shield or C.P.S. re-

serve in California should equal 50 per cent of an annual income from dues.

Expressed in terms of the annual income, the Blue Cross now has 9.62 per cent of its annual income from dues as a reserve.

Blue Cross North has a reserve of equal to 24.56 per cent of its annual income, and C.P.S. has a reserve of equal to 27.14 per cent of its annual income.

Therefore, it would appear that all of the so-called voluntary plans in the State of California are in sound financial condition. There is none of them that is in difficulties financially, and the medical profession, I think, can look with pride, particularly at C.P.S. and it strong finances.

As you pass from the room today, there are printed financial statements of C.P.S. which will be distributed to you if you are interested. On the last page you will find a list of the Government bonds in which C.P.S. funds are invested.

C.P.S. has divided its reserves into savings accounts in banks of standing, banks which pay at least 2 per cent interest, and which have agreed that, if needed, the funds may be withdrawn without notice.

Also, C.P.S. has invested the balance of its funds in short-term Government securities, no security going beyond February 1954.

The plan of the present administration to raise interest rates has made it seem inadvisable to invest any funds in long-term securities, and, therefore, any of these securities might be held to maturity and no loss from principal would thus be suffered.

The average income from our Government securities is 2.15 per cent and, therefore, the reserves that have been built up to protect the payments to you doctors and to the hospitals, it is believed, are not only adequate, but so invested that they could be used in case of any difficulty.

The early months of the year, such as February, March, and April, are the high utilization months each year. At that time C.P.S. generally pays out more than it takes in; not always, but generally.

The operation the past year has been successful from the standpoint that the utilization as a whole has been low. This has come about through the elimination of some contracts that have been costly from the standpoint of utilization. It has come about from perhaps a reduction in utilization due to some adverse publicity last year. It has also come about by greater care in the addition of new members.

It might be of interest to you to know that C.P.S. added over 100,000 new members in the past year.

There is a net decrease, of course, because of the change in Southern California, but at the same time the program of development is proceeding now on a rather sound and substantial basis, to the end that the objective is expressed in Dr. Cass' report that C.P.S. be a sound, substantial organization of which any doctor member could well be proud, could be accomplished. Thank you. (Applause.)

SPEAKER CHARNOCK: Thank you, Mr. Hamman. Now that the union of C.P.S. and the House of Delegates has become legally sanctified, we will refer this report to the C.P.S. Reference Committee.

The report of the Secretary and the Treasurer and of the Executive Secretary as reported in the April issue of CALIFORNIA MEDICINE will be referred to Reference Committee No. 2.

VICE-SPEAKER WILBUR BAILEY: That leaves us next with the reports of the Standing Committees, the first one of which is the Executive Committee.

Dr. Donald Lum!

DR. DONALD LUM: Nothing additional.

VICE-SPEAKER BAILEY: Then, under the Auditing Committee, Dr. Lum, perhaps you will comment.

REPORT OF THE AUDITING COMMITTEE

DR. LUM: Mr. Speaker, House of Delegates: The Auditing Committee has prepared the budget for California Medical Association and for CALIFORNIA MEDICINE for the coming year.

Yesterday this budget was studied carefully by the Council and this budget as adopted by the Council will be distributed to you. I would suggest that you study it.

If you have any questions, appear before the Reference Committee, and we will be there to answer and discuss any questions that you may have.

I am sure you will be interested to note that the Council has recommended that the dues for the coming year be reduced from $40 to $36 a year. (Applause.)

VICE-SPEAKER BAILEY: They certainly interpret that as good news, of course.

That will be referred to Reference Committee No. 2.

Now we skip over several here until we get down to Item M, Committee on Public Policy and Legislation. Dwight Murray! (Applause.)

REPORT OF THE COMMITTEE ON PUBLIC POLICY AND LEGISLATION

DR. MURRAY: Mr. Speaker, Dr. Alesen, Dr. Green, members of the House of Delegates: I am very glad to be here to give you a little report on some of the activities that have been going on the past few months. I first thought I would give you just a few words on what was going on in Washington, if I may.

As you know, there was a special meeting of the House of Delegates in Washington on March 14 of this year. At that time they approved the President's Reorganization Plan of 1953. That has gone a long way in promoting the right type of atmosphere in Washington.

We feel each time we are there, each time we talk to any members of the administration, that the cordiality between the administration and the American Medical Association, or the profession of medicine in the United States is improving. That, gentlemen, is very heartwarming, I assure you.

There are a few things that have come before the National Congress that I think you might be interested in particularly. I don't believe I will be able to tell you anything that you don't know already. I am sure you all read the *Journal* and keep up with everything that is reported in there.

The doctors' draft law perhaps occupies the spotlight of all legislation that has come to Washington this year. As you know, we had a doctors' draft law; then the Department of Defense introduced a doctors' draft law, then the House Committee after studying the two laws, and after hearing quite a number of people and quite a bit of information in the way of testimony, then introduced its own bill. This bill at the present time embodies practically everything that the medical profession asked for.

I think I told you at the meeting in December in San Francisco that there were about 15 to 18 points, particularly, the American Medical Association was holding out for. Most of them have been embodied by the House bill.

Now, at the present time, or this past week at least, the Senate Committee of Armed Services—the chairman, of course, is Senator Saltonstall of Massachusetts—has been hearing testimony on the doctors' draft bill. The same testimony, or practically the same testimony given before the House Committee was given before the Senate Committee. This testimony was received very well. There was no sharpshooting. There was no sarcasm, and we have every reason to believe that the Senate committee will include or endorse the recommendations that have been made by the medical profession. Nobody knows until it is through the hopper, the final product, but we are hopeful that it will be satisfactory insofar as a doctors' draft bill could be satisfactory.

The one thing that seems to be agreed upon by everybody is that there should be no priority form. In other words, if a man has served two years, that will be that, and his term of service for the Government will be finished, except in case of dire emergency. That met with great approval by everybody.

At the present time the $100 extra compensation is under some discussion. There are two ways of going about that, and we are approaching it from both of those angles.

Senator Hunt from Wyoming has introduced a bill to have that $100 a month continue. As I understand it, rather through the grapevine, the Department of Defense has introduced that also, and has cleared the Bureau of the Budget. That may not be exactly true, but anyway it is being considered very well, although a good many members of the House Committee objected to it.

Now, as to things that we hear about over the radio, what are we going to do, or why didn't we do this, or why didn't we do something else, with regard to the old problem of Social Security and all of the things that might come up in that department. Well, we were told very definitely by many of the leaders of Congress that the way to approach that—and they are just as cognizant of the things that are going wrong in that department as we are, probably more so—that they wished to leave that to a committee which is to be appointed, a 25-man committee. It was first thought it would be 13 men, but they change it to 25. Thirteen of these will be appointed by the President, six by the President of the Senate and six by the Speaker of the House. These men that the President is going to select are not all members of the Congress by any means. He expects to appoint Governors from some of the states. He expects to appoint some industrialists, and others, who are interested in the entire problem.

Also, Congressman Curtis, as you know, is carrying on quite a study in the House on this whole welfare setup. That is under very serious consideration at the present time, and it is before these committees that I think the American Medical Association can best express itself; that will be done when the proper time comes.

I believe other things of interest to you are these: On the 25th of this month we have a committee appearing before a committee of Congress that is to study the medical care of rabies. That is important to us. That is a question that has been studied by both houses, chiefly by the House of Representatives, and that is under consideration. Tomorrow, the 25th, our committee from the American Medical Association will appear and give testimony.

I could talk on quite at length about the things that are happening there, but these I think are of prime importance to us here.

Now, the thing that we are most interested in from a legislative point of view is what is going on in California and what has happened, what might happen, and so on. I could not give this report myself at all. I would like permission at this time, Mr. Speaker, to have Ben Read give the House a play-by-play report, so to speak, of what has gone on at Sacramento this year. I would like to have Mr. Read.

VICE-SPEAKER BAILEY: Thank you, Dr. Murray. If there is no objection, Mr. Read will be recognized. (Applause.)

MR. BEN READ: Mr. Speaker, officers, Members of the House of Delegates: Our report will be rather brief, because it is in the nature of a progress report.

The Legislature is still in session and many matters are still pending and undecided; as soon as the Legislature has adjourned, or as soon as possible thereafter, on June 10, we will give you a more detailed report.

This has been the fastest-moving and most hectic session of the Legislature that I have ever seen in my few years around the Capitol. A total of 5,501 bills have been introduced. In addition there are 98 constitutional amendments and 504 resolutions. That is the largest number of bills that the history of the state has ever seen.

We have gone through those carefully, we thought, although we found a couple the other day that about eight of us missed, and we found over 500 that require watching; 304 that require constant attention,

and I have seen some of you present who have been at these committee meetings who know what we mean by "constant attention." It is not 24 hours a day, it is usually 26 or 30.

These bills fell into about 36 different categories, all affecting public health or the practice of medicine.

In his opening address to the Legislature, Governor Warren stated he would not again propose compulsory health insurance, but if anyone else desired to do so, he would support the bill if he thought it proper. A bill was introduced. It is Assembly Bill 3138, by Assemblyman Collins of San Francisco, and is the old C.I.O. bill.

To date, no attempt has been made to secure any action upon it, give it a committee hearing or pay any particular attention to it.

Also two bills have been introduced by Senator O'Gara of San Francisco to set up catastrophic health insurance in which the state would underwrite catastrophic health insurance. Neither of those bills has been moved as the term is used in the Legislature. They have not been set for a committee hearing, and since the time is getting short, we don't know whether they will still be brought before the Legislature or not.

The C.M.A. sponsored fifteen bills, and seven of these have been signed and are law. Others are either on their way through the Legislature, or have been dropped because their provisions have been attained in other ways.

I have copies of the signed bills here in case anyone should be interested.

The Board of Medical Examiners sponsored four bills which were approved by the C.M.A.; rather, four bills sponsored by the Board have been signed into law. They sponsored others, but not all of them have been cleared through the Legislature.

Now, the C.M.A. and Board bills relate to technical changes in the Medical Practice Act which have been found necessary as time goes on and matters change. One of the most important is the so-called injunction bill which gives the Board of Medical Examiners or ten or more persons holding physicians' and surgeons' licenses, the right to apply for an injunction or restraining order against persons who have engaged in or are about to engage in violations of the Medical Practice Act. I don't think I need to elaborate further as to the importance of such a measure. That passed the Legislature early in the session, and has been signed by the Governor, and will become a law in ninety days after the Legislature adjourns, or in September.

Revisions of the Dangerous Drug Act as agreed upon by the interested ethical professions have passed the Legislature and have been signed by the Governor.

The codeine bill has been signed into law. It permits certain codeine combinations to be dispensed on oral prescription, but it must be borne in mind that the Federal regulations still prevail, and until some changes are made there, and we understand changes are on the way, those provisions still prevail. So we hope none of our friends will get into too much difficulty on that. However, that bill did draw a lot of attention throughout the state. We are happy to report through the combined efforts of the physicians, dentists, pharmacists, and all interested groups, it became law.

The disability insurance law has been amended to give $10.00 per day for twelve days while the ill person is in a hospital. This is an increase of $2.00 per day, and the bill is on its way through the Legislature.

Senate Bill 199, while you don't grasp that by number, I think you know the general subject. We have had it up for many years. The various state institutions say they have great difficulty in recruiting physicians, and for years they have been permitted to employ unlicensed physicians, provided those persons have made the proper application to the Board for examination, and are properly qualified, and they are permitted to work for a period of not to exceed two years. Then they must take the examination, or rather, successfully pass the examination, or cease working for the state institutions.

We have had a great deal of argument on that. We still feel the state institutions and State Personnel Board can find licensed physicians, but they say they can't. This year the whole thing was worked over, all of the old sections were repealed, and it was placed into one bill, and that bill expires in 1955. We may have another hassel at that time, but we hope this situation is finally wrapped up in one package.

Twenty-one bills affecting hospitals have been introduced, some of them very important to the hospitals and to you in your procedures in the hospitals. There have been eleven bills amending the Vocational Nursing Practice Act. Some of them have passed the Legislature and are on the Governor's desk, and none of them have met any particular opposition.

Senate Bill 1797 by Senator Thompson of Santa Clara County, to set up an examining committee in the Board of Medical Examiners to license practical nurses, has been given approval by the committee and is now in the Senate Committee on Finance.

A bill to license naturopaths under control of the Medical Examiners has passed the committee and is in the Senate Committee.

One of the bills that has brought the greatest amount of mail to the Legislature has been the rabies control bill. That bill was the result of study by the C.M.A., State Department of Public Health, veterinary groups, and others, and as originally drawn it was quite an elaborate bill. It drew so much objection that it was amended down into just a local control bill, providing that an endemic area may be declared after proper hearings, and then in those endemic areas no dog is permitted to run at large and all dogs must be inoculated.

The antivivisectionists have had a field day on that. Frankly we can't see how they could object to it at the present time. They certainly ought to

love their own dogs enough to want them inoculated against rabies, but they have carried on a terrific campaign of mistreatment, and all the usual stuff that you have met in the past.

We have been successful in getting that bill out of the Senate Committee on Agriculture, and I say "we" advisedly, because it is really the problem of the State Department of Public Health and the livestock groups, wool growers, et cetera, and we were only called in actively on it a couple of days before the first committee session. It has been referred to the Senate Committee on Finance.

Another subject that has drawn considerable mail has been the psychology bills. There are three bills in to regulate the practice of psychology, and all taking a more or less different form of attack upon the situation.

When the first bill was called up for committee hearing last Tuesday, there were about thirty different people in the room, and I am certain there were thirty different opinions. What is going to result out of these three bills, no one knows. I understand some of the leaders of one psychology group say they feel the Legislature should study the matter further.

Another most important bill is Senate Bill 1066, sponsored by the C.M.A., and approved by the insurance groups and labor. It has passed the Senate, and is in the Assembly Committee, and it is very brief.

I will read it to you. "The Industrial Accident Commission may, after public hearings and by an order signed by four members, adopt an official minimum medical fee schedule."

That will be heard in the Assembly Committee on Thursday evening, and while I said in my opening remarks we are not trying to prognosticate, we have a pretty good hope that bill is going to come out of committee, because the labor groups and insurance groups will be there with us.

Your legislative program to date is in good shape. No legislation considered inimical to the public health and high professional standards has passed the Legislature as of this date, and many approved measures have been enacted.

There are eighteen days remaining, and those will be the most crucial. Those are the days when the committee meetings are held hurriedly, and things are brought up out of the archives that we thought might be sleeping, and brought to life, and amendments offered; frankly, we have done the same thing ourselves once in a while, so we must not criticize the other fellow too much. But, we will have to be on the job very assiduously the next eighteen days.

It has been a pleasure, of course, as always, to work for you, and we hope when the Legislature finally adjourns we will be able to give you a pretty good report of the work that you have made possible by your assistance at home. Thank you. (Applause.)

VICE-SPEAKER BAILEY: Thank you, Mr. Read.

Will you continue, Dr. Murray?

DR. DWIGHT MURRAY: Thank you.

I tell Ben Read he is like whisky; the older he gets, the better he gets. This year has certainly been a good time to prove it.

As he stated, it has certainly been a fast-moving session, and at times it takes four or five to be there at one time to listen in on the committees to find out what is going on, to find out whether some testimony should be given, or should not be given, and it is pretty hard to spread the skirts of one man that wide.

I hope you have noticed in the report that we have finally been able to get some positive legislation. I mean by "positive legislation," legislation of our own which we think will help the practice of medicine, which will help the people of our state.

That has not been possible in years past because we were fighting a defensive game all the time. Now we are gradually emerging from that defensive area to the offensive, and these bills that Mr. Read told you about that have been passed, that have been introduced either by the California Medical Association or Board of Medical Examiners, certainly are of great value to the profession and to the welfare of the people of our state.

I want at this time to thank the members of the Council, particularly the Chairman, and all of the other members of the Council who have helped us so well and so much at the Legislature.

I want to thank our President and our President-Elect. The have both been before the committees and the Legislature. And I want to thank the staff, Mr. Hunton, our friends who have assisted us, such as Ed Clancy and Ben Read; and then finally I want to say to you that our legislative program could not carry on if we didn't have the advice and assistance of our legal counsel. That, I think, is probably one of the most crucial, one of the most important things with reference to our legislative program. I am sure that when I get out of the room here that there will be a certain young man over here take me by the nape of the neck, but that is all right. I am on the floor now, and I want to tell you that the services that have been rendered by Mr. Hassard have been invaluable to the whole profession of California.

I want to thank the people on whom I have called. We have to call on members from all over the state, and one of the nice things that has come to me as chairman of the Legislative Committee for these several years is that I have never been refused by a man to come to Sacramento, if it was humanly possible for him to come. The thing that is discouraging to them, and it is discouraging to us—it is embarrassing beyond words—is to have men come, maybe all the way from Los Angeles or San Diego, to Sacramento, or from Eureka or Yreka, or any other point in the state, and then the bill for which we asked them to come to testify for some reason or another is not called up for hearing, and they have to come back.

Now, that has happened every year, and it has happened this year, and I suppose it will happen every other year. But, gentlemen, we can't control those things. We do our best, but there are some things that we just can't control.

We want you to know that when such disappointment comes, that we are more keenly disappointed perhaps than anybody else.

As usual, we have had the assistance of the medical profession in Sacramento. We have enjoyed their assistance for a number of years, but this year it seems to have been better than usual. It seems to have been organized so that if there is something needed—what I mean is the urgent illness of one of the members of the Legislature or his family, that a physician is there within minutes; not hours, but they are there as fast as is humanly possible for them to get there.

That is a great sense of satisfaction to us, and believe me, gentlemen, that is something that we have that nobody else has. Everybody else can say they can do this, or they can do that, or something else, but that is a service that we can give, and the members of the Legislature always appreciate it.

I would like at this time for the Surgeon General of the Legislature, Dr. Frank MacDonald, to stand and take a bow. Could we ask him to stand?

(Applause for Dr. MacDonald.)

And he is just that. His assistance is always readily and willingly given.

I have been very fortunate this year in having the services of a young man in Sacramento, and I don't know how I could have carried on this session of the Legislature without his assistance. He is capable and willing, and is on the job.

At this time I would like, if you will, Mr. Speaker, to call on Dr. Daniel Kilroy of Sacramento.

VICE-SPEAKER BAILEY: Dr. Kilroy, will you stand so we can see you, please? (Applause.)

DR. MURRAY: I would like him to come forward.

VICE-SPEAKER BAILEY: Will you come forward, please, Dr. Kilroy?

DR. MURRAY: Dr. Kilroy is due recognition, gentlemen, because certainly he has done a fine piece of work.

VICE-SPEAKER BAILEY: Dr. Kilroy, do you want to say a few words?

DR. DANIEL KILROY (Sacramento): Thank you, sir.

My report is going to be most brief, and rather general for the same reasons that Ben Read outlined, namely that our work is still unfinished, and possibly more important, the Legislature still in session.

I have been markedly impressed by this current session of the Legislature, at the meetings at which it has been my privilege to attend and to observe the activities of the Legislature in some considerable degree.

My over-all impression is that of a gigantic task placed on the shoulders of our elected representatives.

I am pleased not only as a doctor, but as a citizen with the very high caliber of men and women who represent the people of this state at Sacramento. They have approached their task this year in an unusually serious vein, and with one objective, that of economy standing out over all others. Remember that these same representatives are citizens who are giving long hours of their time away from their own private enterprises, for which service they actually receive a mere pittance, so that we may profit through having at Sacramento as our representatives some of the finest brains in the State of California. One can develop nothing but admiration, respect, and appreciation for their civic devotion.

I have been impressed by the large number of bills introduced in an attempt to gain through legislation in lieu of education all those rights and privileges in the field of medicine now possessed only by those with proper training. I have been even more impressed by the ability of the legislators who, though devoid of medical training, so consistently see through to the basic purport of these various measures. They consistently weigh the public good against these fringe bills, and invariably the bill is found wanting.

It has been most gratifying to me to see the complete cooperation on the part of the medical profession with your Legislative Committee. When a call goes out from Dr. Murray, asking members of our profession to drop everything and come posthaste to Sacramento to assist us on some measure, the cooperation has been absolutely 100 per cent. Without such cooperation, our work would be absolutely ineffectual.

I have been more impressed with the tremendous detail of hard work which is required to keep constantly in touch with the progress and changes in the various measures as they move through the Senate and through the Assembly. I have noted the transformation in our old friend Ed Clancy, from a happy, smiling Irishman, to an acute case of legislativitis, with typical peptic ulcer phases. Ed has worked long and hard in the interest of medicine, and certainly deserves our thanks.

Ben Read, with his ever calm and quiet manner, has been constantly at his post. Without Ben's advice and guidance, we would soon become a group of legislative incompetents. To Ben must go much of the credit for the success of the constructive medical policy established by our legislators.

Hap Hassard practically became a resident of Sacramento as a result of the considerable call upon his services over the past five months. I have been constantly impressed by Hap's ability to take a bill, consisting of a mumbo-jumbo of unintelligible words, and with unexcelled clarity tell us what the bill really says. His presentations before the various committees of the Legislature reveal the unusually acute legal mind from which they have originated. I am sure Hap well knows the deep appreciation of the Legislative Committee and of the members of the California Medical Association for his many services.

I have learned much in the medical legislative field during this last year, and a large measure of that information has been gained by observing the adroit and skillful manner in which the chairman of your Legislative Committee, Dwight Murray, has

handled the multitude of problems presented. The bottomless well of information which Murf possesses makes his work appear deceptively easy. I would hesitate to think where we might have headed in this and past years with less experienced and able hands at the helm. We owe Murf a debt of gratitude which we can never repay. Thank you. (Applause.)

DR. DWIGHT MURRAY: Thank you very much, Dan.

You will all agree with me he is a good-looking, smart Irishman, won't you? (Laughter.)

Just a few more words, and I shall finish my report.

This session of the Legislature, as you know, ends June 10. Our next session of the Legislature will necessarily be before a new group. We hope that practically all of the members will be back, but that will be up to the people of California to decide. Half of the Senate, of course, will be reelected in 1954.

Now, this is May, and 1954 is not very far away. Now, why have we such fine types of men in Sacramento as we all know, and as has been very well pointed out by Dan Kilroy? Because of you at home. You have taken an interest in these things, and you have looked over the candidates, and you have selected candidates that would be a credit and are a credit to your own community, and a credit to our state.

Now, gentlemen, that same task will be before you in 1954. Eighty Assemblymen and twenty Senators. We ask you to do the job as you can do, and as you have done in the past, to screen carefully the candidates, that they will be the right type of men, that they will stand for high professional standards and for the improvement and betterment of the public health generally.

If you will do that, I think you can say as the boys say, after they have returned from a trip over the enemy lines, "Mission accomplished." So, if you will do that, that will be fine. Thank you very much. (Applause.)

VICE-SPEAKER BAILEY: Thank you very much, Dr. Murray.

Anyone who has been near Sacramento has but to reflect for a moment on the complete medical chaos that would occur if men like this didn't help us, and help us continually.

Next is a report by Mr. Ed Clancy, Committee on Public Relations. Mr. Clancy!

I think you know Mr. Clancy well enough without further introduction.

REPORT OF COMMITTEE ON PUBLIC RELATIONS

MR. CLANCY: Mr. Speaker and Members: President Eisenhower in addressing the delegates of the American Medical Association in Washington on March 14, said:

"We do have faith that the Americans want to do the right thing, and the medical profession will provide the kind of services our country needs better with the cooperation and friendship of the Administration, rather than its direction or any attempt on its part to be the big 'poobah' in this particular field."

The furtherance of these services continues to be the main objective of your public relations department.

Statewide, county by county, the principles of grass roots public relations have been set in operation. These include emergency medical care, care regardless of ability to pay, and the creation of forums within the various county societies where misunderstandings between patient and physician may be aired.

In a report of this nature there is always the tempting opportunity to "dress some windows."

However, we would rather report what others have said of our mutual objectives, particularly the establishment of 'round the clock medical care.

Mr. John Long, general manager of the California Newspaper Publishers Association, has written:

My dear Ed:

Seeing one of your advertisements giving an emergency telephone number to call to get a doctor quickly in the West San Gabriel Valley just reminded me to write and tell you of the excellent reaction I have been receiving from publishers around the state to your program of grass roots public relations.

This statewide cooperation is best exemplified by our Sacramento experience. Here, you know, the profession is on display to all the members of the Legislature and those whose duties bring them to the state's capital.

The following letter from Mr. T. F. Knight, Jr., legislative director for the California Manufacturers Association, should be reassuring to all members of the profession as to the fine job your colleagues are doing in Sacramento. In his letter to the Sacramento society, Mr. Knight wrote:

On my arrival in Sacramento in January, Mr. Ed Clancy gave me a card to use in the event I was in need of medical attention. Such occasion arose at the ungodly hour of 2:30 a.m. a week ago today. The number on the card was called and a very prompt reply was made by Dr. Louis E. Phipps. His very able assistance to me was deeply appreciated from both a psychological and medical standpoint.

Such a program as you have in Sacramento is a job well done and an excellent public relations program.

During the past year, the profession has announced its various public services in 750 newspapers. That this service is appreciated is indicated by the many favorable editorials from one end of the state to the other. An example is from the Pasadena *Star-News* whose editor wrote:

With a commendable sense of service to the public, the physicians of Pasadena and other principal cities in the state maintain a 24-hour telephone service through

which doctors may be called for emergencies. . . . The doctors are to be congratulated upon a fine demonstration of public duty.

Commenting on another service of the profession, and this surely is from the grass roots, the editor of the St. Helena *Star* wrote:

Physicians of Napa County, along with other units of the California Medical Association, have set up a Public Service Committee, for the better resolving of any misunderstanding which might arise between patient and doctor. Purpose is to bridge the gap which sometimes exists between a large medical organization and its patients. This is a worthwhile move, particularly, we would say, in large centers, where it is not possible for a doctor to know the background of his patients so well as in a small town.

It seems a wise move to restore the family doctor type of relationship, a move well in line with good public relations.

Radio station owners likewise have been most cooperative.

During the past year 121 radio stations have carried 1,612 fifteen-minute public service programs without cost to the profession. The total time amounts to 403 hours. And, though we've not attempted to translate this time into dollar-value, a quick appraisal indicates it to be more than the entire budget for your public relations department.

Quite naturally, plans are also going forward for television programs in both Los Angeles and San Francisco. Through the fine cooperation of KTLA-TV here in Los Angeles, an extended series of live medical programs is being prepared for early release as a public service feature. This will bring authoritative medical information to the public through the medium of direct participation by doctors themselves.

Of less dramatic interest but of importance in the over-all picture, C.M.A. members have ordered 805,160 "Reminder" cards and 200,080 Health Records. Comments received from the public compliment the profession on these services.

In our opinion, the profession is at its very best when it heralds new advances in the science of medicine and brings new hope to the suffering. The profession is playing an equally important role when it denounces spurious remedies and names the names of the so-called remedies and the charlatan promoters.

The recent cancer expose is a case in point and caused the Los Angeles *Times* to declare:

The action of the California Medical Association in establishing a panel to expose and discredit spurious cancer "cures" and take firm action against doctors using them is warmly applauded. Here is an example of a profession rightly jealous of its reputation taking strong and positive action to preserve it and at the same time protect the public.

Likewise, the profession has met its obligation to the public when your leaders announced that gamma globulin was not a certain prophylactic for poliomyelitis and that it would be in short supply. Here again, you have received much editorial support throughout California.

Forthright actions, such as those outlined, will keep American medicine from the control of the political "poobahs."

However, we in the public relations department are deeply concerned about the "poobahs" *in* medicine.

These people in high places account for headlines such as "Medical Abuses Scored by U. S. Surgeons' Leader."

After "scoring the abuses," the statements always conclude that the infractions are by but a few members of the profession.

The recent flurry started in a national news magazine had repercussions in the nation's press for over two months, thus undoing much of the positive work of public relations departments in all states.

It is our opinion that too long has the vast majority of the profession suffered from the misdeeds of those oft-mentioned "few." (Applause.)

We are convinced that those who make headlines could best use the authority vested in them to *eliminate* the oft-mentioned "few." It cannot be done with printers' ink!

If they cannot accomplish *positive* results for the profession, again in our considered opinion, these "poobahs" should be relegated to Gilbert & Sullivan roles of "royal water meter readers" and they should take the "few" with them! (Laughter and applause.)

We would like to conclude this supplementary report with a sincere commendation of the many county societies, including the very small ones, which have developed sound local programs in the public interest. Their accomplishments, as will be indicated by a review of the preconvention bulletin, add greatly to California medicine's public relations. To all societies, we repeat that your public relations department is *at your service!*

To the officers and Council of C.M.A., the Public Relations Committee and the Advisory Planning Committee and to the executive secretary and legal counsel, we extend our deep appreciation for their understanding, cooperation and counsel in our *positive* program to keep medical economics in step with medical science.

Respectfully submitted. Thank you.

VICE-SPEAKER BAILEY: Thank you, Mr. Clancy.

That report, as well as Dr. Murray's report, will be sent to Reference Committee No. 1.

Any further comments by the Cancer Committee?

I merely point out the information supplemented by what Mr. Clancy said: At the present time due to

the work of Dr. Macdonald and Dr. Garland and other members of the Cancer Commission, there is now a list of drugs. It is handy; if you get a telegram from New York saying, "How about that?" you merely refer to the list. I am sure you all have requests for such information.

Are there any other reports of Standing Committees? If not, we will progress to the special committee reports.

Delegates to the American Medical Association. Dr. Gordon MacLean will give that. Dr. MacLean!

Reports of Special Committees

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

DR. MACLEAN: Mr. Speaker, members of the House of Delegates: I have been requested to give a very short, thumbnail, two-minute report on the activities of the delegates to the American Medical Association.

I would like to emphasize that our business back there is to take your business back there; so, if you have anything that you wish us to carry out, please bring it in to the House of Delegates here so you may pass on it.

It is difficult at the last moment to be presented with resolutions to take back where we are going to meet with the American Medical Association if we don't have instructions from this House.

Your delegation consists of twelve members. That is second, New York being the largest with seventeen. However, we are aided and abetted by three other delegates from sections who happen to be from California. I assure you these men are very, very helpful indeed.

Your delegation is very active. It has taken part in the three meetings that we have had during the last year; the special meeting in Washington, perhaps, was one of the most interesting. Dr. Murray has told you about what took place there, but I believe we all came back with the impression after listening to President Eisenhower and Mr. Taft and Mr. Judd, that we are represented now by men who are going to be fair to the medical profession.

I know I was greatly impressed by the President's geniality, his sincerity, and when he was sitting down at rest, with his grim determination.

I have talked to many members from the deep South, and they, I believe, all have about the same idea concerning the President. They were very, very kindly toward him.

I might tell you just about what your delegation does. It arrives usually a day before, and has breakfast at half past seven or eight o'clock, immediately gets down to business and maps out what the program is going to be for each day.

We take up the various resolutions or business as it comes along. We follow things going to the committees, and I assure you that one of the delegates or the alternates—and may I say here the alternates have been most helpful—is assigned to committees to see what happens and to offer discussion, if necessary, but especially to report back to our delegation each morning at breakfast what is going on. That way we keep in very close contact with the business going on in the American Medical Association.

Now, we have a very representative group of men. We have very good speakers. We have men who are very good at committees. We have others who are very good, let us say, at working in smoke-filled rooms, and other out-of-the-way places. (Laughter.) I am sure that you will find this sort of work pays off in dividends.

At noontime we entertain each day at luncheon any delegate who wishes to come up to our room, and I assure you those are very well attended luncheons.

In the afternoon, or at what other time it may be, we attend meetings of the House of Delegates, Reference Committees, and in the evening you will usually find a group of California delegates out with groups of delegates from other parts of the country. So, your California delegation, I believe, is very well-known indeed.

We have been very fortunate in the past year with having official representation. As you know, Dr. John Cline is immediate Past President.

Dr. Dwight Murray was on the Board of Trustees, and chairman of the Board, and we were very fortunate indeed, I believe the American Medical Association was extremely fortunate when it elected Vincent Askey as Vice-Speaker.

I believe without doubt, within a year or two, when his time comes, he will be Speaker of the House of Delegates of the American Medical Association.

Now, just in case you think this purely a hard-working organization, I assure you that it is. But, at the same time we have quite a lot of time for fun, and when we come home looking rather tired, that wasn't all due to putting in long hours working at our jobs. We had to have a little fun along with it, but I assure you that you are represented by an organization of men which is a very functional one, and what is more important, very agreeable and very sociable. Thank you. (Applause.)

VICE-SPEAKER BAILEY: Thank you, Dr. MacLean, for your report on smoke-filled rooms, and other "out-of-the-way places."

As a matter of fact, I watched these men at work, and he is very modest when he says they aren't working all the time.

Your report will be referred to Reference Committee No. 1.

Next is the report of the C.P.S. Study Committee. I will report it went out of effect in the last meeting.

You have already heard from Dr. Alesen about the amalgamation of Blue Cross and Blue Shield.

The next speaker, Dr. Leslie Magoon, will speak on the Medical Services Commision. Dr. Magoon!

REPORT OF MEDICAL SERVICES COMMISSION

DR. TEALL: Mr. Speaker, members of the House: In case there is any question, I am not Dr. Magoon. Dr. Magoon asked me to render this supplementary report on behalf of the Medical Services Commission, and if there is any question in anybody's mind, my name is Teall.

You will find the printed report in the preconvention Bulletin, but because your Medical Services Commission is the judge of your permanent organization, and yet has potentially perhaps the greatest job after C.P.S. of anything the C.M.A. has, we want you to be thoroughly aware of the way we are groping toward our assigned objectives. For that reason I just want to report on what has happened since the preconvention Bulletin was prepared.

Since the published report was prepared, the Medical Services Commission has held two meetings, each preceded by a meeting of its Executive Committee.

On March 21 and 22 a joint meeting with the California section of the Health Insurance Council of the United States was held at the Biltmore Hotel in Santa Barbara. At this meeting a number of problems of mutual interest to the commercial insurance carriers and to the members of the California Medical Association were discussed in great detail. The insurance representatives expressed themselves as being very pleased at the opportunity to discuss their problems with an organization representing our state society. The conferees from each group greatly increased their basic understanding for future guidance.

On April 18 and 19, the commission met in San Francisco and heard extensive discussion of health insurance problems in Australia by Dr. C. H. Dickson, the secretary of the Victoria Branch of the British Medical Association, a discussion from Mr. Ransom Cook on his personal observations of present European health insurance schemes, and discussion from Mr. K. L. Hamman on possible future mutual problems of the Medical Services Commission and California Physicians' Service.

At the April meeting a committee was organized to define the principles which should go into the establishment of fee schedules sponsored by the C.M.A., such as the C.P.S. schedule. It is felt that such principles are basic to any further activity of the Burnham Committee of Eight and to integration of activity of fee schedule committees with functions of the Medical Services Commission.

The Medical Services Commission is now preparing, with the Public Relations Department of the California Medical Association, a brochure for distribution through doctors' offices discussing various aspects of the problems of health insurance. Final action is expected on this pamphlet at the meeting of the Commission to be held concurrently with this State Convention. Semi-final action is also expected at this meeting on the "principles" of voluntary health insurance which have been under study by the Medical Services Commission since its organization.

VICE-SPEAKER BAILEY: Thank you very much, Dr. Teall.

Dr. Teall, normally that would go to Reference Committee No. 1, and there we shall put it. If it should happen that you would prefer to have the report sent to C.P.S. Reference Committee because you think it might be more appropriate, you can tell us so later.

We have the Committee on Industrial Health next. Christopher Leggo cannot be here. He sent a supplementary report as follows:

REPORT OF COMMITTEE ON INDUSTRIAL HEALTH

VICE-SPEAKER BAILEY (reading): "To the President and the House of Delegates:

"Your Committee on Industrial Health is gratified to report that the California State Nurses' Association has been most receptive to the 'Nursing Services in Industry: A Statement of Principle,' which was published in the April 1953 CALIFORNIA MEDICINE as a committee report.

"In keeping with our invitation, the California State Nurses' Association has edited the statement, and in so doing, has clarified, in the opinion of your committee, the meaning in some sections, and has, we believe, so strengthened the entire statement.

"The draft they have presented is being submitted to the Council, with a recommendation that it be approved for issuance as a joint statement of the California Medical Association and the California State Nurses' Association.

"Respectfully submitted."

VICE-SPEAKER BAILEY: Are there any further standing committee reports or special committee reports, or reports of officers? We are asking particularly, because we have short-cut this program a little in the interest of saving time. But we don't want to exclude anybody who should be heard.

We will have announcements at the end of the period.

. . . Announcements . . .

VICE-SPEAKER BAILEY: Now, Dr. Garland.

DR. L. HENRY GARLAND (San Francisco): Mr. Chairman, I understand Dr. Macdonald of the Cancer Commission does have a supplementary report on the Cancer Commission, and he is in the back of the room.

VICE-SPEAKER BAILEY: Dr. Macdonald, will you come forward, please?

SUPPLEMENTARY REPORT OF THE CANCER COMMISSION

DR. MACDONALD: Supplementary to the regular report of the Cancer Commission, the Commission wishes to offer the following resolution:

WHEREAS, The Cancer Commission of the California Medical Association has, after careful investigation, demonstrated the ineffectiveness of certain agents proposed for the treatment of cancer; and

WHEREAS, The said Cancer Commission has evidence of the use of these agents in private practice by certain members of the California Medical Association; now, therefore, be it

Resolved, That this House of Delegates request component county societies to take appropriate action toward the investigation and appropriate disciplining of those members who persist in using such unproved remedies for cancer without facilities for investigational purposes under controlled, scientific conditions.

VICE-SPEAKER BAILEY: Thank you very much, Dr. Macdonald.

Resolutions at this particular moment are a little out of order, but unless anyone objects, we will put that resolution over to Reference Committee No. 3.

We would like Dr. Macdonald to have it in triplicate by the time that you can. Those things can be arranged, if you ask our Secretary.

There seems to be a certain amount of curiosity about when we get through this afternoon. Perhaps we can tell you what we have in mind next. As of the Wednesday meeting, between two and four, Dr. Charnock and I have agreed, if it meets with the consent of the House, to have an Executive Session. It may not last until four, but, at least, it will start when we reconvene. That is important because some of you perhaps will wish to have your resolutions discussed at that time.

At the present time, unless there will be no objections, we would like to have the reports of Reference Committees Nos. 3 and 4, and then go to the report of Reference Committee No. 1, which will probably be done after lunch.

If there is no objection to having the report of Committee No. 3 at this time, we will proceed with that.

Report of Reference Committee No. 3. Dr. Halley is going to make the report.

Dr. E. C. Halley from Fresno.

REPORT OF REFERENCE COMMITTEE No. 3

DR. HALLEY: Mr. Speaker, and members of the House of Delegates:

Your Reference Committee No. 3 was appointed April 27, 1952, and with the 1953 Annual Session, will have served at three consecutive sessions. The membership of this committee has been composed of Dr. E. C. Rosenow, Jr., of Los Angeles County, Dr. Francis Rochex of San Francisco County and Dr. E. C. Halley of Fresno County. We submit the following report dealing with and making recommendations on all matters submitted to Reference Committee No. 3 at the 1952 Interim Session of December 6 and 7.

The committee received, from the House, seven resolutions for consideration. Three of these resolutions, to-wit, Nos. 1, 3 and 4, were voted as emergency resolutions and were acted upon and disposed of at the Interim Session. Resolution No. 9 was introduced at the 1952 Annual Session and brought before the House at the 1952 Interim Session but at the suggestion of its author and by the vote of the House was recommitted to Reference Committee No. 3. We have therefore for your consideration at this time the five following resolutions.

Now, you have all had copies of these resolutions sent to you, and I presume that it isn't necessary to read these resolutions if I merely refer to them by way of their content.

VICE-SPEAKER BAILEY: If it suits the House, it would suit the Speaker. Probably you had better give us a little summary on each one. Thank you.

DR. HALLEY: Well, I will give you a brief summary of each one as presented, and I think that should suffice to clarify what we have under discussion at the particular moment.

Resolution No. 9 refers to the desirability of amortizing the cost of technical and professional education, and recovery of said costs through income tax deductions.

Now, at the Annual Session in May 1951 a similar resolution was defeated by the House when the Reference Committee pointed out that precedents and decisions had been established in the Internal Revenue Department against such amortization. Your present Reference Committee explained in its report at the last Interim Session that the editorial referred to in this resolution concerns the Reed-Keogh Bill dealing with voluntary pension plans for self-employed professional individuals. We also stated that this resolution proposed tax considerations equally germane to many professions other than the medical profession and with the Reed-Keogh Bill still a live issue, there must be some limitation on what the medical profession should ask for all at one time. Feeling that nothing additionally helpful would be accomplished by the adoption of this resolution, we recommended a do not pass at that time.

It was brought to our attention that after the preparation of our last report "There has been some change in the prospects for political thinking in Washington and secondly that Congress took no action on the Reed-Keogh Bill. Therefore, the committee comments were not pertinent."

We of the committee feel that our comments were valid at the Interim Session and even more so at this time. The Reed-Keogh Bill is still a live congressional issue, not a dead one. To quote from *Medical Economics*, February 1953, "The proposal will almost certainly be voted, eventually. But tax-writing Congressmen say that 1953 won't be the year because the Republicans are grimly determined to balance the budget. Leaders have decided that further revenue losses must be avoided. Besides, it is axiomatic that one tax equalization measure means opening the door to hundreds of others."

It would seem that a portion of the cost of a professional education is retrieved by fees intended to be higher than a laborer's wage. If our fees are to be eventually dictated to us by others, the request might have more significance. With the average in-

come of physicians being at a higher point than at any time in our history, we feel Congress would at this time look with misgiving on a program which would set such a precedent of giving tax relief by permitting amortization of educational expenses.

For the reasons here recited your committee again recommends that this resolution do not pass.

Mr. Speaker, I move the adoption of this section of our report.

VICE-SPEAKER BAILEY: Do I hear a second?

DR. DONALD CASS (Los Angeles): Second.

VICE-SPEAKER BAILEY: You understand this is before you from the Interim Session. Therefore, it has to be adopted or otherwise now. We are, therefore, open for discussion. Any comments?

... The question was called for....

DR. BURT DAVIS (Santa Clara County): I think that the report of the committee misses the point somewhat. I think that the report of the committee also admits that there is a certain amount of inequity in the way in which all professional people, not only doctors, but lawyers and surveyors, and every other type of person, has to spend more money on his education than the common laborer. I wish merely at this time, for the sake of emphasis, and I hope the chairman of the committee won't consider me impertinent, to read an editorial from the *Fresno County Bulletin* which appeared in the May 1953 issue.

Over the editor's signature it states, "Do you believe that physicians should be permitted to make amortization deductions in their income tax to recover the cost of professional education? Logically it would seem that this expense should be deductible as well as later expenditures for postgraduate or refresher courses. A taxpayer can recover amortization deductions only for the amounts invested in property used for the production of income. Property does not mean simply tangible, physical property. It means intangible as well, such as leaseholds, patents, copyrights, et cetera. The question is, can the knowledge and skills that the physician acquires through the years of study also be considered as property? From the economic viewpoint, there is no reason why a physician or other professional person should be treated differently from a businessman. The businessman must invest in physical equipment before he starts producing goods or services and earning income. The physician makes a comparable investment in acquiring the knowledge and skills to be used in carrying on his work.

"As Mr. Justice Cardozo once said, 'Learning is akin to capital assets.' It is apparent then that professional men with an expensive education would stand to gain by a change in the present rule. Only an investment in property as now restrictively defined may be amortized in taxes, but there is good reason for redefining the word 'property.'"

The joint committee in the Internal Revenue Bureau is improving the tax laws. Why not accept this invitation and try to receive more favorable tax consideration?

We have all heard the squeaking wheel gets the grease. Let's make a few squeaks. (Laughter and applause.)

VICE-SPEAKER BAILEY: Thank you, Dr. Davis.

Is there further discussion?

There being no further discussion, the Chair will put the question.

You recognize that the committee recommended do not pass. Therefore, if you vote "aye," you are agreeing with the committee that we shall do nothing further with the situation.

All those in favor say "aye."

... The motion was put to a vote....

VICE-SPEAKER BAILEY: The Chair is in doubt. Those in favor please rise.

... A standing vote was taken, and it was carried....

VICE-SPEAKER BAILEY: Dr. Halley, will you proceed, please?

DR. HALLEY: Resolution No. 2 refers to making medical and dental expenses fully deductible for income tax purposes.

Your committee is of the opinion that any method of providing tax relief for the prevention, cure, correction or alleviation of a bodily condition would be most appropriate at this time. We have, however, changed the second paragraph by striking out the words enclosed in parenthesis, to-wit: (less than 5 per cent of gross income). This deletion in no wise changes the intent or meaning of the resolution, whereas the retention of the words makes for inaccuracy of fact and however interpreted is at variance with income tax law. In Long Form 1040—"The law allows you to deduct only those medical and dental expenses which exceed 5 per cent of your adjusted gross income."

The committee recommends that this amended resolution do pass.

Mr. Speaker, I move the adoption of this section of our report.

VICE-SPEAKER BAILEY: Is there a second?

... The motion was seconded....

VICE-SPEAKER BAILEY: Any discussion on this suggestion?

DR. CHARLES A. NOBLE, JR. (San Francisco): It seems to me this resolution has a great deal of merit at this time, and besides that, anything of this sort that is pushed by the medical profession may gain for us increasing good public relations. But if the resolution as introduced should be passed, it seems to me there is a certain inequity.

For example, in the lower income tax bracket, suppose someone had a bill of hospital and medical expenses on the order of $1,000 or $1,500, and that family's total income tax liability for a year were of the order of only $100 or $150. The tax relief so afforded would be quite small, and incommensurate with that tax relief that would have been afforded someone in a much higher income tax bracket.

It therefore seems to me that one might make provisions in such a bill so that that tax relief can

be carried forward for several years. There is precedent for this. In a certain number of income tax provisions, like those of capital losses, there is provision for carrying over those losses; also the same for capital gains, I believe.

Therefore, although I think this is not allowed, Mr. Speaker, I would like to amend that resolution merely by adding a phrase. That phrase would be, "and to include a provision—"

VICE-SPEAKER BAILEY: Where do you add this phrase now?

DR. NOBLE: I will read the whole thing.

VICE-SPEAKER BAILEY: Yes, go right ahead.

DR. NOBLE: In the very end of the resolution, "and to include a provision that the deduction may be carried over for several years."

In other words, the last resolve would read as follows: "That the California Medical Association through its American Medical Association delegates seek to encourage national legislation which will permit medical expenses actually paid by the taxpayer, such as doctor, hospital, laboratory, drugs, and dental expenses, and health and accident insurance premiums to be completely deductible by the patient for income tax purposes, and to include a provision that the deduction may be carried over for several years."

VICE-SPEAKER BAILEY: Thank you very much, Dr. Noble.

DR. ERNEST W. HENDERSON (Alameda): Is that good to say "several years"?

DR. NOBLE: That is the point. It was only a recommendation to the group in the east.

VICE-SPEAKER BAILEY: Therefore, since it is a recommendation, we don't have to be too specific. Dr. Hodges.

DR. FRANCIS T. HODGES (San Francisco): May I suggest the use of "amortization," rather than "carried over a few years."

VICE-SPEAKER BAILEY: How do you feel about that?

DR. NOBLE: It is perfectly all right.

VICE-SPEAKER BAILEY: You make that motion?

DR. NOBLE: Yes.

VICE-SPEAKER BAILEY: And you second it?

DR. HODGES: Yes.

DR. STANLEY R. TRUMAN (Alameda): Mr. Speaker, our legal adviser doesn't suggest that.

VICE-SPEAKER BAILEY: Will you tell us about it, Mr. Hassard?

MR. HOWARD HASSARD: If the cost or expense for medical care exceeds the individual's income in a given year, the unused portion may be carried forward against income in succeeding years. "Amortization" is the wrong word, because that has to do with the depreciation or depletion of a capital asset. (Laughter.)

VICE-SPEAKER BAILEY: Dr. Hodges, are you unamortized by this time? (Laughter.)

Now, the amendment stands before the House as seconded by Dr. Hodges, and now it is in its original form, I take it everyone agrees.

Is there any further discussion? This is on the amendment. There is none.

Those in favor of the amendment say "aye."

... The motion on the amendment was put to a vote and it was carried....

VICE-SPEAKER BAILEY: Dr. Halley, then the question goes back to the original section, and that has been seconded already as amended.

Is there any further discussion?

All those in favor of the original as amended will say "aye."

... The motion was put to a vote and it was carried....

VICE-SPEAKER BAILEY: Dr. Halley, will you continue, please.

DR. HALLEY: Resolution No. 5 pertains to the basic sciences in relation to the healing arts.

Your committee feels that this subject of basic sciences in relation to the healing arts should be investigated. We are of the opinion, however, that until the problem has been fully studied, to formulate legislation would be premature. Therefore, we recommend a substitute resolution as follows:

Resolved, That the President of the California Medical Association appoint a committee whose function shall be to investigate thoroughly the problems involved in such requirements and report to the Council.

Your committee recommends that this substitute resolution do pass.

Therefore, Mr. Speaker, I move the adoption of this section of the report.

VICE-SPEAKER BAILEY: Is there a second?

... Calls of "second"...

VICE-SPEAKER BAILEY: Are you ready for discussion?

... The question was called for....

VICE-SPEAKER BAILEY: Any discussion?

Dr. Foster, you are the author of this resolution. Will you please speak to the question?

DR. THOMAS FOSTER (Santa Clara County): Thank you, Mr. Speaker.

It was considered that the functions were sequential, and the investigation would precede formulation, and formulation would, in turn, precede seeking legislative relief. If it is necessary to spell it out, I believe that can and should be done. Otherwise, I can see no need to emasculate this resolution and confine it simply to investigation. It is something that is long overdue and much needed, and I think we should put no roadblocks in its way.

I could see only one other objection, that this commission might proceed without approval of the Council, and I think perhaps that should be in the resolution as well.

So, if I may then, Mr. Speaker, I will propose to amend this by the substitution of the original mo-

tion with modifications which would then read as follows:

"*Resolved*, That the President of the California Medical Association appoint a Commission whose sequential functions shall be, (1) to thoroughly investigate problems involved in such requirements, (2) to formulate suitable legislation with the aid of legal counsel and other informed sources, (3) with approval of the Council, to seek legislative relief, utilizing such public relations counsel as appears necessary and desirable successfully to achieve this goal."

VICE-SPEAKER BAILEY: Doctor, just a minute before you go back, so we have this thoroughly in mind. Do you mean to amend the suggestion of the committee this way?

DR. FOSTER: I propose to amend the committee's amendment by the substitution of the revised original amendment in which I make two changes; one change being that the function shall be sequential, and the second change that Council approval shall be necessary before seeking legislative relief.

VICE-SPEAKER BAILEY: That is all right. We will put that in the form of an amendment, then.

Is there a second to the amendment?

... It was seconded....

VICE-SPEAKER BAILEY: Any discussion on the amendment?

A MEMBER: I have a question. What does "counsel" mean? How is that spelled?

... There were calls of "c-i-l." ...

VICE-SPEAKER BAILEY: Probably we have to have both, as a matter of fact. That is the amendment. If there is no further discussion, we will vote on it.

... The motion was put to a vote and it was carried....

VICE-SPEAKER BAILEY: We will proceed to the committee's report as amended.

Is there any further discussion on that subject?

DR. HOWARD C. MILES (Monterey County): I want to support Dr. Foster in his recommendation on this resolution. I feel too long in the past the initiative in promoting legislative programs in the state has lain in the hands of the fringe groups.

As Dr. Murray pointed out, we have in the past been on the defensive, engaging in a holding action, with our legislative program in the state and in the nation.

We are now gaining confidence in our legislative program, and it is time now we get on the offensive.

I think that this resolution is a step in the right direction to make the basic science requirements mandatory in the state.

The Reference Committee's recommendation to refer this to a commission for study without any positive action coming out of the study, takes away from this resolution the thing that makes it important. And that is making ourselves prepared to offer a legislative program when the time is ready.

So, I would recommend that we approve the resolution as amended by Dr. Foster, and not as recommended by the Reference Committee.

VICE-SPEAKER BAILEY: Dr. Miles, we have approved the resolution as amended.

Probably the Chair can shorten debate on this by saying what Dr. Miles has just said is undoubtedly the opinion of the House, because this has come up in the Council and we have discussed it before.

Perhaps this is the way to do it; unless there is some objection to the particular method, we would have to continue and ask that you follow the committee's "do pass" or vote against it, if you don't want it as amended. Therefore, unless there is further discussion, the Chair will put the question.

All those in favor of the committee's report as amended will say "aye."

... The motion was put to a vote and it was carried....

VICE-SPEAKER BAILEY: Dr. Halley, will you proceed?

DR. HALLEY: Resolution No. 6 refers to the inadequacy of medical services in various communities, and suggests surveys and studies concerning these inadequacies.

There are several committees of the California Medical Association and the American Medical Association already active in obtaining information relative to the inadequacy of medical services in various communities. We, therefore, recommend that this resolution be referred to the Council for appropriate action.

Mr. Speaker, I move the adoption of this section of our report.

... The motion was seconded....

VICE-SPEAKER BAILEY: Is there any discussion?

All those in favor will say "aye."

... The motion was put to a vote and it was carried....

VICE-SPEAKER BAILEY: This is referred to the Council for appropriate action.

Now, Dr. Halley.

DR. HALLEY: Resolution No. 7. This resolution pertains to methods of providing subsidies for physicians in areas lacking adequate medical personnel.

Until the information referred to in Resolution No. 6 is obtained and interpreted, we are of the opinion this resolution is premature.

Your committee, therefore, recommends a *do not pass.*

Mr. Speaker, I move the adoption of this section of our report.

VICE-SPEAKER BAILEY: Is there a second?

DR. DONALD CASS (Los Angeles): Second.

VICE-SPEAKER BAILEY: Dr. Burt Davis, will you speak to the question? You are the originator of both six, which has just passed, and seven which is up for debate.

DR. BURT DAVIS (Santa Clara County): In view of the fact that both of these resolutions pertain to the same subject, one being authorization for the

study of the problem, I differ slightly with the verbiage of the report, in that I claim it is a reputed problem and not necessarily actual.

In view of the fact the subject covered by the two resolutions is so closely interwoven and interrelated, I would move that the committee report be referred to the Council along with the previous resolution.

VICE-SPEAKER BAILEY: Is there a second to that?

... The motion was seconded....

VICE-SPEAKER BAILEY: That is a motion to refer this to the Council. Is there any debate on the motion to refer this to the Council? I hear none.

Those in favor will say "aye."

... The motion was put to a vote and it was carried....

VICE-SPEAKER BAILEY: That, therefore, completes your report, Dr. Halley?

DR. HALLEY: Mr. Speaker, I now move the adoption of the report of Reference Committee No. 3 as a whole as amended.

... The motion was seconded....

VICE-SPEAKER BAILEY: All those in favor of adopting the report as a whole as amended will say "aye."

... The motion was put to a vote and it was carried....

DR. HALLEY: I would like at this time to thank the members who served faithfully for three sessions on this committee with me. I also thank you who appeared at our meeting last December in the interest of these resolutions. I want to assure you it has been a pleasure to have tried to serve you. (Applause.)

VICE-SPEAKER BAILEY: Dr. Halley's committee made an all-time high in length of time of a Reference Committee.

... Announcements....

VICE-SPEAKER BAILEY: The morning session is drawing to a close. We want, however, before adjourning to luncheon until two o'clock, to make a few announcements.

Under the circumstances, I would like very much to have the Speaker introduce the Past Presidents of the Association.

SPEAKER CHARNOCK: Ladies and gentlemen: Those Past Presidents who are present, will you stand, please.

Dr. George Kress. (Applause.)

I will say this is Dr. Kress' fiftieth anniversary.

Come up and say a word, Dr. Kress.

PAST PRESIDENT KRESS: Mr. Speaker and members of the House of Delegates: I can only express to you and the other members of the profession who sit here, after many, many years of service in the profession, my appreciation of the honor that you have extended in asking me to come to the platform.

My memory goes back over a great many meetings of the House of Delegates. One of these days, perhaps we will put it all in written word, to outline the procedures of days gone by when things did not move along with quite the smoothness that has been evidenced here this morni..g.

I have been very much impressed with the ability of members of the House of Delegates in their capacity to express to you all in such clarifying manner the business that is before you.

I realize as I grow older that the problems of medicine never grow less.

Thank you very, very much. (Applause.)

SPEAKER CHARNOCK: Thank you very much, Dr. Kress.

Dr. Edward Ewer.

Dr. Lyell Kinney, a member of the House. (Applause.)

Dr. Junius Harris.

Dr. George Reinle. We have seen him up here this morning. (Applause.)

Dr. Robert Peers.

Dr. Harry Wilson.

Dr. William R. Molony, Sr.

Dr. Karl Schaupp.

Dr. Lowell Goin.

Dr. Sam McClendon. (Applause.)

Dr. John Cline. (Applause.)

Dr. E. Vincent Askey. (Applause.)

Dr. R. Stanley Kneeshaw. (Applause.)

Dr. Donald Cass. (Applause.)

Dr. H. Gordon MacLean. (Applause.)

... Announcements....

SPEAKER CHARNOCK: We are now in recess until 2:00 o'clock.

... The Sunday morning session adjourned at 12:00 o'clock noon....

Sunday Afternoon Session

The Sunday afternoon session of the House of Delegates, California Medical Association, was called to order at 2:00 o'clock in the Renaissance Room of the Biltmore Hotel by Speaker Donald A. Charnock, who presided.

SPEAKER CHARNOCK: Will the House please be in order.

We have two or three announcements to make.

... Announcements....

SPEAKER CHARNOCK: At this time it is a great pleasure to present to the House of Delegates six members from our Student American Medical Association.

I am going to ask the young gentlemen to stand up here in front as their names are called.

Don Casebalt and William Tryon, from the College of Medical Evangelists. (Applause.)

Les Smith and Wallace Sampson, from the University of California at San Francisco. (Applause.)

Bruce Nichols and George Mulfinger, from the University of Southern California. (Applause.)

I am going to ask Don Casebalt if he will speak one word for the entire group.

DON CASEBALT: I know I speak for all of us when I say it is a real pleasure and privilege for us to

attend the meeting of the House of Delegates and see how organized medicine works.

I would like to say a word of thanks to you for Bruce Nichols and myself for sending us to the Convention in Chicago. As most of you know, the California Medical Association footed the bill for our going, and we appreciated that.

We are glad to be here today. Thank you. (Applause.)

SPEAKER CHARNOCK: Thank you, Don Casebalt, and you other gentlemen very much.

The next order of business will be the report of Reference Committee No. 4. Dr. Arthur Kirchner, chairman, reporting.

REPORT OF REFERENCE COMMITTEE No. 4

DR. KIRCHNER: Your Reference Committee No. 4 is composed of Dr. Wayne P. McKee, Dr. Albert G. Miller, and myself.

As you know, one of our perplexing problems has been the elimination of the Interim Session. We are up here the third time on this problem. We have batted perfectly for recent admissions.

You recall that at the Interim Session, Dr. Robertson Ward of the San Francisco delegation submitted a By-Law amendment, in which he asked that the Interim Session be cancelled by a two-thirds vote of the Council.

Well, after considerable debate it was decided to resubmit to the committee, and you asked the committee to return something that would be more suitable.

So, here we are again, and it seemed to the committee that the House of Delegates desired some acceptable middle ground between the elimination of the Interim Session on the one hand and its mandatory convening on the other.

The committee felt that many delegates do not want the decision each year to rest with the Council or the officers of the Association.

As the middle-of-the-road decision, the committee offers the following new substitute for Dr. Ward's By-Law Amendment No. 3.

Resolved, That Section 7 of Chapter V of the By-Laws of this Association, California Medical Association, be amended by adding the following new sub-section thereto:

(e) Prior to the Annual Session in each year, the Council may elect to recommend to the House of Delegates that the Interim Session for such year be cancelled. If such recommendation is made, it shall be presented to the House of Delegates at its first meeting during the Annual Session prior to the introduction of resolutions, and the House shall thereupon vote to accept or reject said recommendation. If said recommendation is accepted, then the Interim Session for that year shall be deemed cancelled; in which event all resolutions and new business introduced at the Annual Session may be acted upon thereat, and the requirement in Sub-Section (c) above that non-emergency resolutions must not be acted upon until the next session shall not apply.

You will note the new proposal gives a vote to the House of Delegates. Such a vote must occur early in the Annual Session in order to avoid confusion as to whether non-emergency resolutions may lie on the table until the next session or may be introduced and voted upon at that time. This substitute amendment gives the opportunity to eliminate the Interim Session in any year it is deemed inadvisable to hold it, and at the same time does not deprive the House of Delegates of the authority to make the final decision.

Now, this is a new By-Law amendent and for that reason cannot be voted upon at this time, and will be voted upon Wednesday.

This is the last report of Reference Committee No. 4, and we, like Three, have been up here three times. We want to thank all of you who have appeared before us. We want to thank the Legal Counsel, the Executive Secretary's office for the many revisions that had to be made, and so on; and for all of you who have been so very patient with us in presenting these By-Law and Constitutional amendments.

Thank you.

SPEAKER CHARNOCK: Thank you, Dr. Kirchner.

As Dr. Kirchner related to you, this is an entirely new amendment to the By-Laws, and will lie on the table until Wednesday.

The next order of business is the report of Reference Committee No. 1, Dr. Douglass Batten reporting.

REPORT OF REFERENCE COMMITTEE No. 1

DR. BATTEN: Mr. Speaker, and members of the House of Delegates:

Two matters of business were placed before this Reference Committee at the Interim Session of the California Medical Association held in San Francisco, December 1952. They were:

1. Final report on recommendations Nos. 4 to 14 of the C.M.A.-C.P.S. Study Committee Report and

2. A resolution submitted by Dr. Frederic P. Shidler of Menlo Park, California.

With the permission of the House, Mr. Speaker, I should like to consider Dr. Shidler's recommendation first, contrary to the matter as published.

SPEAKER CHARNOCK: That is within your privilege.

DR. BATTEN: The author of this resolution, Dr. Shidler, has asked me to express for him the fact that he wishes to withdraw the resolution completely from the House of Delegates. Therefore, it requires no action.

SPEAKER CHARNOCK: Unless there is an objection from the House, we will withdraw this portion of the report; otherwise, we will vote upon it.

Hearing no objection, it is withdrawn.

You may proceed.

DR. BATTEN: Thank you.

This committee has again considered in detail the C.M.A.-C.P.S. Study Committee Report. A few communications concerning it have been received.

This committee is again deeply impressed with the tremendous amount of effort, time, and sacrifice that must have gone into the preparation of this far-reaching report. Its searching and astute observations in the field of insurance and medical practice are impressive. It is felt that in these days of unrest and changing social conditions with their impact upon the physician and his method of practice that such a plan as outlined in the C.M.A.-C.P.S. report would provide the beginnings of an answer to a problem with which the medical profession must concern itself more and more in the coming months.

One of the many valuable features of the report that this committee wishes to commend is the retention within the structure of C.P.S. of the service-type plan of prepaid, voluntary health insurance; while at the same time permitting that organization to delve into the relatively unexplored aspects of the indemnification type of Blue Shield insurance in California.

Another feature of the report on which this committee cannot help but pass comment is the very wise retention throughout of free choice of physician by the patient and the continuance of the unhampered and unfettered physician-patient relationship that has existed throughout medical practice.

We feel that the C.M.A.-C.P.S. plan has great merit.

This committee believes it would be advantageous for the various component medical societies to undertake promptly the basic work of establishing fee lists for use in their respective areas. The committee also feels that it would be advisable for those counties wherein the membership is strongly in favor of these proposals to initiate such a program at the earliest opportunity. In this manner experience and additional valuable information could be gained.

It is the considered opinion of this committee that any definite action on the part of the House of Delegates concerning the specific recommendations 4 through 14 would be premature at this time and should not be undertaken. The committee feels that the program would be successful only where a strong majority of doctors were in favor of it and that therefore it should be tried first only in specific counties where such a majority exists.

There was established by this House of Delegates at the regular meeting in 1952 a Medical Services Commission which is charged in part with these duties:

"To study, keep records upon and recommend action to the C.M.A. and its component bodies on all types of prepaid medical care; including C.P.S., insurance company plans, industrial accident schedules, union labor plans, voluntary-compulsory governmental and non-governmental plans."

This commission, through its regularly functioning channels of information is constantly being advised of the latest developments in the field of insurance, labor union-management negotiations, prepaid health schemes, and the new colossus on the horizon—the Department of Health, Education and Welfare.

This permanent commission, composed of respected and esteemed physicians throughout the state, can readily advise and coordinate the various county medical societies in their attempts to establish such a fundamental revision in the practice of medicine as is proposed in the C.M.A.-C.P.S. report.

It also appears to us that the Medical Services Commission is in an especially advantageous position to advise the Council of the C.M.A. upon matters of public and professional education as proposed in recommendations Nos. 10 and 11.

This committee therefore recommends that the C.M.A.-C.P.S. Study Committee report be referred to the Medical Services Commission for further study and such action as that body may deem advisable and necessary.

This committee further recommends that any component county medical society which wishes to institute an active program in accordance with these proposals do so under the guidance and with the cooperation of the Medical Services Commission.

It is suggested that the Medical Services Commission report to the House of Delegates through the Council of the C.M.A. at the next session of the House of Delegates concerning any additional information or experience which may have been acquired concerning the program and to make any additional recommendations the commission may then deem advisable.

Mr. Chairman, I move the adoption of this section of the report.

SPEAKER CHARNOCK: Is there a second?

... The motion was seconded....

SPEAKER CHARNOCK: It is now open for discussion.

Dr. Sherman, from San Francisco!

DR. SAMUEL R. SHERMAN (San Francisco): Mr. Chairman, members of the House of Delegates: I hereby wish to submit the following amendment to the C.M.A.-C.P.S. Study Committee report that any place in this report where reference is made to a fee schedule or a fee list, it be firmly understood that such fee schedule or fee list shall be subject to review and revision by duly appointed members of the medical profession at least every two years, and that such revision be tied to the current cost of living of the United States Bureau of Labor Statistics.

I make this amendment because of the fact that if such fee schedules are adopted in this report, we would be bound by a rigid fee schedule which would perhaps act as a millstone around our neck. With this safeguard, such an objection would, therefore, be obviated. Thank you.

... The motion was seconded....

SPEAKER CHARNOCK: There is a second.

Do you want to vote on this amendment now? Is there any discussion on it?

... The question was called for....

SPEAKER CHARNOCK: It has been moved and seconded that this amendment that Dr. Sherman has

just given be attached to the Report of Reference Committee No. 1.

Those who are in favor of the amendment will signify by saying, "aye."

... The motion was put to a vote and it was carried....

DR. JUSTIN J. STEIN (Los Angeles): I recommend this be referred to the appropriate committee for study, and be brought back to the Wednesday session for final action.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that this report be referred to the Reference Committee. The motion to refer has a higher precedence than the motion, and it has been moved and seconded. I am going to ask Dr. Bailey to explain this to you.

VICE-SPEAKER BAILEY: Mr. Chairman, we all know that it is the job of the Speaker and Vice-Speaker to try to make things flow as smoothly as possible. We know the county societies have talked this over at great length. Many of the caucuses of the different counties have not had a chance to talk among themselves. We also know there are a number of amendments coming up on this same subject. So, it would seem, with the permission of the committee which originated this report, that we should put the whole thing together and come out with something definite, by sending it all to the C.P.S. Reference Committee. That doesn't mean by any means it is being postponed indefinitely. It is being postponed definitely, so the whole thing can be taken up at once before the C.P.S. Committee.

That is the object of this motion, as I understand it, Dr. Stein?

DR. STEIN: Yes.

VICE-SPEAKER BAILEY: Then the motion is before you to refer this to the C.P.S. Committee.

SPEAKER CHARNOCK: Now, is there any discussion about referring this to the C.P.S. Reference Committee?

DR. L. HENRY GARLAND (San Francisco): A point of order, Mr. Speaker. Do you mean refer the report as amended?

SPEAKER CHARNOCK: Refer the report as amended to the C.P.S. Reference Committee. Is there any discussion?

A MEMBER: A point of information.

SPEAKER CHARNOCK: What is your point of information?

SAME MEMBER: When would that committee report back?

SPEAKER CHARNOCK: Wednesday.

A MEMBER: That is what I wanted to know.

SPEAKER CHARNOCK: The committee would report back Wednesday.

A MEMBER: Will we have an opportunity now to know all the proposed amendments to it, or will this stop any other amendments that may be offered on this floor?

SPEAKER CHARNOCK: No, you can put the amendments in when we call for new business.

Is there any more discussion?

... The question was called for....

SPEAKER CHARNOCK: Dr. Batten, do you want to discuss this any further?

DR. BATTEN: No, sir.

SPEAKER CHARNOCK: The motion now is to refer this report to the C.P.S. Reference Committee. Those who are in favor will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is referred.

DR. BATTEN: In closing, I simply wish to thank the members of the committee, Dr. James W. Moore and Dr. Roland R. Jantzen for their steadfast help throughout the last six months in completing this report. (Applause.)

SPEAKER CHARNOCK: I think we ought to give a great vote of thanks to all these committees that have been working through these sessions.

The next order of business is to call upon the Secretary for any old or unfinished business.

SECRETARY DANIELS: None.

SPEAKER CHARNOCK: There is no old or unfinished business.

The next order of business is new business, and before we go into that I should like to repeat to you that the mechanism for turning in emergency resolutions is as follows: Under Chapter V, Section 7, Paragraph (d) of the By-Laws, emergency resolutions must be designated so by the proposer and read before the House by the proposer. The House will then vote whether or not it sees fit to make this an emergency resolution. This vote must be by a two-thirds vote in order to make it an emergency resolution. If the two-thirds vote is in the affirmative, it is sent to the Reference Committee and brought back to the House at the Wednesday meeting. A two-thirds vote will be required for passage. If the proposition is of such grave emergency, it is within the discretion of the Chair to have you vote on it immediately.

If the House does not consider that the resolution or proposition is of an emergency nature, then the resolution is lost.

However, the member may reintroduce this as a regular resolution during the time of introducing resolutions, and at that time it will lie over as the ordinary resolutions.

I will now recognize Dr. Sidney Shipman, who will make resolutions on behalf of the Council.

RESOLUTIONS AND AMENDMENTS

DR. SIDNEY SHIPMAN (San Francisco): Mr. Speaker, members of the House: The first resolution that I would introduce this afternoon on behalf of the Council is an amendment to the Constitution which, of course, will have to lie over for a year.

You may not have noticed, but the Councilors-at-Large are not actually members of this House at the present time, and we wish to make them such. To that end:

Resolved, That Article III, Part A, Section 1 of the Constitution of this Association, the California Medical Association be amended by striking out the word "District" in sub-section (c) of said Section 1, so that Section 1 will read as follows:

"Section 1.—Composition

"The House of Delegates shall consist of:

"(a) Delegates elected by the members of component societies;

"(b) Officers of the Association as hereinafter provided;

"(c) Ex officio, with the right to vote, the Councilors, and

"(d) Ex officio, without the right to vote, the Past Presidents."

SPEAKER CHARNOCK: This will be referred to Reference Committee No. 4, and will lie over until the next session.

DR. SHIPMAN: The second is a resolution which has to do with certain special technicians and skills such as technicians in nuclear energy, people who deal with encephalograms on a technical basis and that sort of thing:

WHEREAS, It is imperative for the development of scientific medicine that well-trained and qualified people with special skills, postgraduate training and higher degrees such as Ph.D., work with doctors of medicine in developing new methods of treating the ill and aid in the measuring of these new methods after they have been developed; and

WHEREAS, These people with special skills, regardless of proficiency in a particular field, are, nevertheless, not trained in the over-all skills embraced within medicine and surgery; now, therefore, be it

Resolved, That the medical profession recognize these special skills and urge that they be used at all times and that people with special skills, postgraduate training and higher degrees, such as Ph.D., be allowed to analyze all functions of the body, the excretions and secretions of the body, or make any other measurement with instruments on the body for statistical purposes in cooperation with doctors of medicine; and, be it further

Resolved, That in no instance, except where specifically prescribed by law, should these people of special skills, postgraduate training and higher degrees such as Ph.D., be permitted to make diagnoses or render diagnoses to doctors of medicine, hospitals, clinics, et cetera; and, be it further

Resolved, That such persons with special skills shall not prescribe for the patient, but that the prescribing of new medicine or medicines requiring the technical skills of these people with special skills, postgraduate training and higher degrees such as Ph.D., be done only by medical doctors and that the care of the people receiving these medicines be under the direction and immediate care of the doctor of medicine so prescribing.

I would like to make this an emergency.

SPEAKER CHARNOCK: This has been proposed as an emergency resolution. It has been moved. Is there a second?

. . . The motion was seconded. . . .

SPEAKER CHARNOCK: It has been moved and seconded that we accept this as an emergency resolution. Is there any discussion?

. . . The motion was put to a vote and it was carried. . . .

SPEAKER CHARNOCK: It will be referred to Reference Committee No. 3 as an emergency resolution.

DR. SIDNEY J. SHIPMAN: The next refers to the Committee on Medical Defense which, as most of you know, has not been active for a good many years:

Resolved, That Chapter VII, Section 1, of the By-Laws be amended by deleting sub-section (c) and relettering the other sub-sections that follow; and be it further

Resolved, That Chapter VII, Section 10 be deleted from the By-Laws of the California Medical Association, with the provision that the following sections shall be renumbered in proper fashion.

It merely brings the matter of this Committee on Medical Defense in proper focus at the present time.

I would like to make this an emergency.

SPEAKER CHARNOCK: That is an amendment to the By-Laws, and will go to Reference Committee No. 4, and will come before the House on Wednesday.

DR. SIDNEY J. SHIPMAN: The next has to do with Dr. Alesen's committee.

WHEREAS, Initiated by Council action, a special Joint Blue Cross-Blue Shield Committee composed of representatives of H.S.S.C., C.P.S. and H.S.C., is currently exploring the possibilities of close cooperation between these professionally sponsored prepayment plans; and

WHEREAS, It is obviously in the best interest of the public, hospitals and medicine alike that the services offered by these plans shall be most efficiently rendered and be made available to everyone who needs them at a price and in a manner that will effectively furnish prepaid health care on a voluntary basis with full freedom of the public's choice of physician and hospital; now, therefore, be it

Resolved, That the Boards of Directors of these three plans be urgently requested to participate actively and wholeheartedly in an attempt to unite and coordinate their offerings in the most feasible and practicable plan available.

I would like to make this an emergency also.

SPEAKER CHARNOCK: Is there a second?

. . . The motion was seconded. . . .

SPEAKER CHARNOCK: It has been moved and seconded that this be made an emergency. Is there any discussion?

Those in favor signify by saying, "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is passed, and declared an emergency and referred to Committee No. 3.

DR. SIDNEY J. SHIPMAN: This is the final resolution:

WHEREAS, Don Cass is completing the maximum six years of service permitted members of the Board of Trustees of California Physicians' Service; and

WHEREAS, He has given unstintingly of his time, effort, and talents without regard to the personal sacrifices involved; and

WHEREAS, This service has been of tremendous benefit to California and California Physicians' Service in this most important period of its development; now, therefore, be it

Resolved, That this House of Delegates express to Donald Cass its sincere gratitude for his work in the public service and to the medical profession alike.

Obviously, this is an emergency. (Applause.)

SPEAKER CHARNOCK: Gentlemen, according to the By-Laws, it has been moved and seconded that this resolution be declared an emergency.

Those who are in favor of such will signify by saying "aye."

... The motion was put to a vote and it was carried unanimously....

SPEAKER CHARNOCK: It is within the discretion of the Chair to have you vote immediately on this.

Those who are in favor of this resolution will please stand.

... Standing applause....

SPEAKER CHARNOCK: Dr. Stein.

DR. JUSTIN J. STEIN: Mr. Speaker, members of the House of Delegates: I wish to make this resolution an emergency resolution because, as most of you know, when the doctor draft law was first introduced, some of us lukewarmly supported it, feeling it was very urgent. But, at the present time, as you know, the Armed Forces wish to continue it for two years, and some for a longer period, and we definitely believe this law should be stopped as quickly as possible.

WHEREAS, The Doctor Draft Law No. 799, 81st Congress, is discriminatory legislation against physicians, dentists and veterinarians; and

WHEREAS, The passage of the Doctor Draft Law originally was recommended only with the consideration that it not be made permanent; and

WHEREAS, During the operation of the Doctor Draft Law many inequities and injustices have been noted; now, therefore, be it

Resolved, That the President of the California Medical Association be authorized to immediately notify the Armed Forces Committee of the House and Senate, the Director of Selective Service, and the chairman of the Health Resources Advisory Committee of the Office of Defense Mobilization and other appropriate officials of the following:

That inasmuch as the American Medical Association has studied the law in its present operation and has called the attention of Congress to the inequities and injustices and have made recommendations for the deletion of the inequities and injustices in the new law, it is urged that the recommendations of the American Medical Association be incorporated in the new Doctor Draft Law.

SPEAKER CHARNOCK: It has been moved that this be presented as an emergency. Do I hear a second?

... The motion was seconded....

SPEAKER CHARNOCK: Is there any discussion?

Those who are in favor of the introduction of this resolution as an emergency will signify by saying "aye."

... The motion was put to a vote and it was carried.

SPEAKER CHARNOCK: It is accepted as an emergency resolution and sent to Reference Committee No. 3.

DR. JUSTIN J. STEIN: This is introduced as an emergency resolution because the California State Legislature at the present time is considering drastically curtailing civil defense funds:

WHEREAS, The needs for civil defense are just as urgent now as ever before; and

WHEREAS, Every effort must be made to insure the adequacy of civil defense measures for the civilian population; now, therefore, be it

Resolved, That the California Medical Association so notify the California State Legislature and urge that there be no curtailment of funds which will impair the efficiency of civil defense.

SPEAKER CHARNOCK: Is there a second to placing this as an emergency?

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that this resolution be accepted as an emergency.

Those who are in favor will signify by saying "aye."

... The motion was put to a vote....

SPEAKER CHARNOCK: The Chair is in doubt. Those who are in favor of accepting this resolution as an emergency will raise their hands.

... The motion was voted on by a show of hands, and it was carried....

SPEAKER CHARNOCK: The motion is won, and it is referred to Reference Committee No. 3 as an emergency.

DR. JUSTIN J. STEIN: This final resolution should also be considered as an emergency:

WHEREAS, Physicians in the Armed Forces have frequently been used for non-medical duties; and

WHEREAS, The ratio of physicians in the Armed Forces to personnel is too great; now, therefore, be it

Resolved, That the California Medical Association request of the Secretary of Defense that better utilization of physicians in the Armed Forces be carried out and that there be a reduction in the amount of non-military medical care and that greater use be made of contract physicians and of existing private medical facilities.

SPEAKER CHARNOCK: Is there a second to accepting this as an emergency resolution?

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that this resolution go in as an emergency. Those who are in favor will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is accepted as an emergency resolution and sent to Reference Committee No. 3.

Does anybody else have any more resolutions?

DR. LESTER LAWRENCE (Alameda-Contra Costa): Mr. Speaker, members of the House of Delegates: I would like to present a resolution pertaining to the economics of the practice of medicine:

WHEREAS, The doctor's personal economy exists within a general economy based upon business and industrial concepts of capital investments and their amortization, operating and production costs, recognized depreciation tables and other factors of modern accounting methods and principles; and

WHEREAS, Medicine has thus far failed to translate its economy into these terms; and

WHEREAS, Medicine must now make its economy understandable so that it can explain and defend fees as based upon the cost of production and delivery of its services; so that it can insist upon taxes computed in equity with consideration for educational capitalization and its amortization; and so that it can gain recognition for reasonable reserves for retirement based upon tables of normal years of production; and

WHEREAS, Accountants of standing and experience inform us that much of the economics of medicine can be reduced to terms and methods, statements and reports of modern accounting; therefore, be it

Resolved, That the Council of the California Medical Association be asked to retain business analysts and accountants as needed to conduct a study for the purpose of translating into present tax and business language and reports the economics of the doctor of medicine; and, further, be it

Resolved, That the initial goals of this study shall be:

1. Establish costs as related to fees.

2. Capitalize the cost of a professional education and the forebearance of income during the educational period, and establish reasonable tables for amortization of these factors.

3. Determine the normal expectancy for years of active practice.

4. Determine minimum retirement funds that should be accumulated and how this cost should be reserved.

5. Establish accounting systems for medicine which can be used to substantiate requests for legislative relief and equity for the doctor of medicine.

SPEAKER CHARNOCK: This will be referred to Reference Committee No. 3.

Dr. Ludwig.

DR. LAFE LUDWIG (Los Angeles):

WHEREAS, The medical schools of the United States are closing each school year with a considerable financial deficit; and

WHEREAS, Such continued practice will eventually lead to government subsidies and intervention in the administration of said medical schools; and

WHEREAS, The doctors of medicine, graduates of said schools, are trained at a rate below actual cost; and

WHEREAS, Voluntary contributions from California physicians have averaged only about $1.00 per capita per annum; therefore, be it

Resolved, That the dues of the California Medical Association be increased $25.00 per year; said monies to be used to support the American Medical Education Foundation.

SPEAKER CHARNOCK: This will be referred to Reference Committee No. 2.

Dr. de los Reyes.

DR. J. M. DE LOS REYES (Los Angeles): Mr. Chairman:

WHEREAS, The greatest privilege that any individual may have is American citizenship; and

WHEREAS, It has become evident in these perilous times that all important organizations should have their membership imbued with the true feelings of real Americanism; and

WHEREAS, The largest component unit of the California Medical Association, to-wit, the Los Angeles County Medical Association, requires all its active members to be American citizens; therefore, be it

Resolved, That the By-Laws of the California Medical Association be amended as follows:

That Section 3, Chapter 2 of said By-Laws will have an added sub-paragraph (e) "Required that membership of all classes is hereby limited to citizens of the United States."

I want to make this an emergency resolution, Mr. Chairman.

SPEAKER CHARNOCK: I don't think that needs to be declared an emergency. It will be sent to Reference Committee No. 4 and brought back to the House on Wednesday. It cannot be done before anyhow.

DR. DE LOS REYES: Thank you.

My second resolution. This resolution is presented

because many of the members of the Congress of the United States would like to know the opinion of some of the bodies like the California Medical Association.

WHEREAS, Every American physician has a double interest in the newly created Department of Health, Education and Welfare, because it affects him professionally as a citizen; and

WHEREAS, The entire Department of Social Security has for years been operated as a deliberate deception and fraud upon the American public in that approximately seventeen billion dollars of old age and survivors trust funds have been transferred to the general fund and used in pursuit of numberless nefarious socialistic schemes while the employee from whom these taxes were collected was led to believe that they were held in trust for him against the day when he should need them when as a matter of fact these funds are represented only by government IOU's; now, therefore, be it

Resolved, That the House of Delegates of the California Medical Association urge the Congress of the United States to speed and accelerate in every manner possible a thorough-going investigation of the entire Social Security program to the end that it may be placed upon an honest and actuarial basis; and be it further

Resolved, That the California delegation to the American Medical Association be instructed to present this resolution to that House at its meeting in New York, June 1 to 5; and be it further

Resolved, That a copy of this resolution be sent to the President of the United States, to the members of the Cabinet, and to each member of the Congress.

Do I have to vote this as an emergency to receive it Wednesday?

SPEAKER CHARNOCK: Yes.

DR. DE LOS REYES: I ask it be placed as an emergency.

SPEAKER CHARNOCK: Is there a second?

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded this be placed as an emergency resolution. Those in favor say "aye."

... The motion was put to a vote....

SPEAKER CHARNOCK: The Chair is in doubt.

Those in favor please vote by raising your hands.

... A vote was taken by show of hands....

SPEAKER CHARNOCK: It is declared an emergency by a two-thirds vote.

Dr. de los Reyes talked about seventeen billion dollars. I thought this should go to Reference Committee No. 2, but we will put it to No. 3.

DR. LYLE G. CRAIG (Los Angeles): Mr. Speaker: I would like to introduce an emergency resolution at the request of the executive committee of the medical staff of the Huntington Hospital:

WHEREAS, There has developed in the United States a marked shortage of interns available for private hospitals, due in part at least to the increasing demands of public, military, and veterans' hospitals; and

WHEREAS, If the private practice of medicine in the United States, to which the American Medical Association is dedicated, is to survive, our newly graduating doctors must not only receive adequate scientific clinical instruction and experience, but must also learn something of the art and economics of private practice, with its highly important personal doctor-patient relationship with its obvious advantages to society; and

WHEREAS, These factors essential to the preservation of our heritage and to the welfare of the public can be far more adequately learned by the intern in our many excellent private hospitals, which can furnish adequate scientific instruction and experience as well; and

WHEREAS, The report of the Advisory Committee on Internships of the Council on Medical Education and Hospitals of the American Medical Association which report has been accepted and published in the *Journal* as the basis for the approval of hospitals for intern training, obviously sets up requirements that can be met only by the larger hospitals affiliated with medical schools, and is definitely prejudicial to the interests of the hundreds of splendid private hospitals, who will find it impossible under its rulings to qualify for intern training; now, therefore, be it

Resolved, That this House of Delegates of the California Medical Association instruct our delegates to the American Medical Association that they shall introduce into the House of Delegates of that organization a resolution that there shall be appointed a new committee for the further study of this problem—one with a more realistic attitude and sympathy with the principle of private medical practice and hospital care—such committee to review and revise the recommendations of the Council on Medical Education and Hospitals, in order that continued opportunity may be given to private hospitals to provide the excellent intern training that they have furnished in the past.

SPEAKER CHARNOCK: Is there a second?

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that this resolution be accepted as an emergency. Those in favor signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is accepted and referred to Reference Committee No. 3.

DR. LYLE G. CRAIG (Los Angeles): This resolution is also designated as an emergency, and is introduced by request:

WHEREAS, The advertising of therapeutic agents in the official journals of the American Medical Association carries great prestige with the medical profession and the public at large; and

WHEREAS, All methods of promotion of any prod-

uct bearing the seal of one of the Councils of the American Medical Association are under control of said Council; and

WHEREAS, Some pharmaceutical manufacturers have failed to take proper cognizance of their grave responsibility in promotion of their products and have tended during the past few years to over-advertise and over-commercialize new therapeutic agents both in official journals of the American Medical Association and through direct mail advertising to physicians throughout the United States; and

WHEREAS, A petition is being presented to the House of Delegates of the American Medical Association in the form of a resolution calling upon officers and committees to exercise great care in the selection of advertising and material from pharmaceutical firms which do not strictly conform with the standards and principles of the Association; now, therefore, be it

Resolved, That this House of Delegates instruct the Delegates to the American Medical Association House of Delegates to work diligently for the enactment of such legislation as will protect the public and the good name of scientific medicine.

I ask this be made an emergency.

SPEAKER CHARNOCK: Is there a second?

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that this be declared an emergency.

DR. ROBERTSON WARD (San Francisco): Can we discuss whether this becomes an emergency or not?

SPEAKER CHARNOCK: I am sorry, Dr. Ward. Your point is well taken.

DR. ROBERTSON WARD: We have missed the opportunity twice now to discuss whether these should become emergencies. I can't see any particular reason for making this an emergency. If we want to go back to the old system of putting all our resolutions before the Reference Committee at the time of their introduction, then we should well vote for this to be an emergency. If not, I can't see any particular reason why this should go as an emergency.

SPEAKER CHARNOCK: Is there any more discussion?

Those who are in favor of accepting this resolution as an emergency will signify by saying "aye."

... The motion was put to a vote....

SPEAKER CHARNOCK: The Chair is in doubt. Those in favor of accepting this as an emergency will put up their hands.

... The motion was put to a vote by a show of hands and it was lost....

SPEAKER CHARNOCK: The motion is lost.

DR. LOGAN GRAY (San Mateo): Mr. Chairman:

WHEREAS, The relation of physician to patient is intimate and personal; and

WHEREAS, The security of the patient is based partly on the feeling that his doctor and his doctor's medical society and associations possess an unconfused dignity; and

WHEREAS, The prestige of physicians, county medical societies, state associations, and the profession nationally has suffered because of an occasional premature publication of controversy between one segment of the profession and another over matters of major policy; and

WHEREAS, This taking the profession's problems to the public over the head of the profession has the effect of inviting a reaction against all physicians, to the eventual detriment of the patient; and

WHEREAS, The press and periodicals cannot be blamed, since they can only utilize such material as they received; now, therefore, be it

Resolved, That the C.M.A. adopt a policy which precludes publication of controversial issues by small or large groups of physicians, until such matters of important policy be decided by full and orderly deliberations of the county and state societies and that the medical profession be urged to settle its own problems without pitting one faction against the other in the public press and journals. (Applause.)

SPEAKER CHARNOCK: This will be referred to Reference Committee No. 3.

DR. MALCOLM TODD (Los Angeles):

Mr. Speaker: I should like to introduce this as an emergency resolution. This is on closed panel practice:

WHEREAS, Current standards of medical practice in the United States are unequalled elsewhere in the world; and

WHEREAS, Freedom of choice of physician, with direct and immediate physician-patient relationship, is essential if patients are to enjoy the best of medical care; and

WHEREAS, American medicine has endeavored in every possible way to make prepaid medical care available to the public on a voluntary basis; and

WHEREAS, In connection with certain prepaid medical care plans, a temporary and purely economic advantage seems to be afforded to an operation under a closed panel system with full or part-time salaried physicians; and

WHEREAS, The interjection of a third party in the physician-patient relationship is obviously undesirable, since the interest of the employer must necessarily be dominant, resulting inevitably in more or less interference with professional practices, as for example, limitation respecting certain procedures and/or materials, the utilization of nurses in lieu of physicians to an undesirable degree, et cetera; and

WHEREAS, While the corporate practice of medicine is illegal in California, the constructive objectives of such law are lost when, in the functioning of a closed panel system, there is superimposed a corporate overlord (or an all-powerful layman) with total and effective control of the closed panel

prepaid medical care plan and of all the employees thereof; and

WHEREAS, In connection with the functioning of these closed panel systems, there is a tendency, when groups are insured—and it is probably an absolute necessity if such systems are to continue to exist—to require that every employee in a given group be covered, thus making "captives" of many unwilling individuals; therefore, be it

Resolved, That the House of Delegates of the California Medical Association, after full consideration, because of the inherent threat to the high standards of medical practice and, particularly, because of the potential injury to individual captive patients, does now and hereby declare that the operation of such closed panel systems in prepaid medical care plans is undesirable and injurious to the public welfare. (Applause.)

Mr. Speaker, I introduce this as an emergency resolution.

SPEAKER CHARNOCK: Is there a second?

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded this be introduced as an emergency. Is there any discussion? The Chair hearing none, will call for a vote.

Those in favor of declaring this as an emergency will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is referred to Reference Committee No. 3.

DR. PAUL V. MORTON (Santa Clara County): I wish to propose this as an emergency resolution:

WHEREAS, The ready availability of blood and blood derivatives has become a vital necessity to modern medical practice and therefore a matter of highest concern to the physician; and

WHEREAS, The independent operation of blood banks of all degrees of excellence throughout the nation by many different agencies, some lay and some medical, has resulted in confused incoordination with its consequent wastage of vast amounts of blood and in friction, competition and open enmity between blood banks and organizations operating blood banks; and

WHEREAS, The general public is confused, irritated, and critical of the varying methods of operation among blood banks in the same or contiguous areas; and

WHEREAS, The high level of civilian demand plus the great needs of the military establishment for blood makes unnecessary waste of blood an unforgiveable error; and

WHEREAS, The professional aspects of the drawing of blood, its fractionation, and its use as a therapeutic tool, must be under medical control, and such medical control on a national scale logically should be a function of the American Medical Association; and

WHEREAS, The American Red Cross has already been designated by government as the official blood recruitment and distributing agency for the nation, and already has demonstrated that its organization is well suited to recruitment programs, to the administration of supplies in meeting disaster relief and civil defense needs, and to the business administration of blood banks; and

WHEREAS, The present American Red Cross program of so-called "free" blood without requirement for replacement has made collection of adequate supplies difficult, has been a tremendous drain on Red Cross funds which might better be devoted to purposes more consistent with Red Cross functions, is inaccurate to the extent that blood is not free but is paid for by the community at large and by government by tax revenues, and is fundamentally inconsistent with the overwhelming belief of the medical profession that no kind of health care should be free to the recipient able to pay therefor; now, therefore, be it

Resolved, That the delegates to the American Medical Association from the California Medical Association be instructed to introduce and support in the House of Delegates of the American Medical Association appropriate resolutions pressing for a coordinated national blood bank program jointly operated by the American Medical Association and the American National Red Cross with the cooperation of other qualified and interested organizations on the following basis:

1. Medical aspects of blood banking shall be under the exclusive control of the medical profession.

2. Business administration, donor recruitment, stockpiling for civil defense and disaster relief, allocation of supplies to meet military needs, and public relations shall be matters of joint concern.

3. The theory of "free" blood shall be abandoned; instead, actual costs of processing shall be charged to the recipient able to pay, and financial penalties shall be applied for failure to replace blood.

4. Coordinated regional cooperative arrangements to improve distribution and avoid waste shall be implemented.

5. The national blood bank program shall be a financially self-supporting but non-profit arrangement operated in the national interest with the sole aim of promoting the widest availability of safe and usable blood and its derivatives.

SPEAKER CHARNOCK: This has been declared an emergency. Is there a second?

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that this resolution be declared an emergency. Is there any discussion?

Those who are in favor of declaring this an emergency will signify by saying "aye."

... The motion was put to a vote....

SPEAKER CHARNOCK: The Chair is in doubt. Will those in favor put up their hands.

... The vote was taken by a show of hands, and the motion was carried. ...

SPEAKER CHARNOCK: The motion has won, and it is sent to Reference Committee No. 3.

DR. ALLEN HINMAN (San Francisco): My name is Allen Hinman. I am not related to Frank Hinman who is chairman of the San Francisco delegation.

I have been requested to present the following four resolutions submitted by members of our delegation and accepted by a majority of our delegation.

The first resolution:

WHEREAS, The passage of time has shown the mandatory Interim Session of the House of Delegates to be an unnecessary drain on the time of our Delegates and on the resources of our Association; therefore, be it

Resolved, That the By-Laws be amended to provide for an optional Interim Session, dependent solely on the need which may occur from year to year, by changing Chapter V, Section 7—"Sessions and Meetings"—of the By-Laws to read as follows:

SECTION 7—SESSIONS AND MEETINGS

(a) In each year there shall be one regular session of the House of Delegates, which shall be held in the first six months of each calendar year and be designated the Annual Session. The time and place of such session shall be determined by the Council as far as possible in advance and notice thereof published in the Journal of the Association.

(b) Prior to the Annual Session each year, the Council may elect to recommend to the House of Delegates that an Interim Session be held in the last six months of each year. If such recommendation is made it shall be presented to the House of Delegates at its first meeting during the Annual Session prior to the introduction of resolutions and the House shall thereupon vote to accept or reject said recommendation. If said recommendation is rejected, or if no such recommendation is presented, resolutions and other new business may be introduced and acted on during the current Annual Session. If said recommendation is accepted, and an Interim Session is to be held during the last six months of said calendar year, resolutions and other new business may be introduced at Annual and Interim Sessions of said year but shall not be acted upon until the next session of the House; provided, however, that any resolution designated as an emergency measure may be acted upon at the session in which it is introduced, as hereinafter provided.

(c) At every meeting of any session of the House of Delegates in any calendar year during which an Interim Session is to be held, as heretofore provided, the Speaker shall designate a time at which any member may request the permission of the House to introduce an emergency resolution for immediate consideration. Such permission shall require a two-thirds affirmative vote of the members of the House present and voting. Such permission having been granted, the resolution must be acted upon during that session of the House, and the Speaker may if necessary, and at his discretion, waive the rule of referring the resolution to a committee. The pasage of such emergency resolution shall require a two-thirds affirmative vote of all members present and voting and the action shall be final for that session.

(d) In addition to the Annual and Interim Sessions, special meetings of the House of Delegates may be called at any regular or special meeting of the Council, by a two-thirds vote of all the members of the Council, or by written call stating the object of the meeting, filed with the Secretary in the office of the Association and signed by one-half or more of the members of the House of Delegates. Upon the filing of such call with the Secretary, the Council shall within thirty (30) days thereafter fix the time and place for the holding of such special meeting and cause written notice thereof stating the object of the meeting to be sent by United States mail, postage fully prepaid, (laughter) to each member of the House of Delegates, addressed to him at his office or place of residence, as shown by the records of the Secretary's office, at least fifteen (15) days prior to the date of the meeting.

SPEAKER CHARNOCK: This is a By-Law change, and will be referred to Reference Committee No. 4 to be acted upon Wednesday.

DR. ALLEN HINMAN: This resolution is to foster improvement of National Defense with respect to military need:

WHEREAS, National Defense must continue to be paramount in the minds of the medical profession; and

WHEREAS, The science and profession of medicine is absolutely essential in National Defense; and

WHEREAS, In the past, until very recently, national military medical personnel needs have been met on a voluntary basis; and

WHEREAS, A state of affairs has come about whereby national military medical personnel needs must be met by draft; and

WHEREAS, Any system of drafting medical officers cannot be as valuable in defense as a voluntary system; and

WHEREAS, Any medical reserve officer program heretofore instituted has not given the reserve officer an even break in his training to assume military responsibility; and

WHEREAS, There has never been decent remuneration for the time consumption, the responsibility, and the wear and tear of the conscientious medical reserve officer; and

WHEREAS, It is the duty of the American Medical Association to point the way to a long term medical defense policy; therefore, be it

Resolved, That the House of Delegates of the California Medical Association instruct its delegates to the American Medical Association to introduce

and foster such resolutions as will tend to achieve the following:

1. Institute a long-term policy in the American Medical Association for the purpose of improving the position of the medical reservist.

2. To set up committees and other necessary permanent personnel to carry out proper negotiations and liaison with government and the American Legion, and otherwise to carry out such policy.

3. To expressly institute in this policy a demand for a fair share of the staggering defense budget to foster and subsidize a voluntary medical reserve corps sufficiently adequate to take care of national needs in time of war.

SPEAKER CHARNOCK: This will be referred to Reference Committee No. 3.

DR. ALLEN HINMAN: This resolution defines and clarifies the usage of the term "free choice of physician."

WHEREAS, The term "free choice of physician" is in regular usage to designate an unrestricted right of a patient to choose as his physician anyone in practice at the time the physician is needed; and

WHEREAS, Organized medicine in California has gone to great efforts to preserve the fullest right of free choice of physician in its own Blue Shield Plan and California Physicians' Service; and

WHEREAS, There is a certain grave danger to the right of good medicine when closed panel groups maintain that they are giving free choice of physician on the basis that there was a choice when the prepayment contract was sold, and that the patient has a right to choose his physician from the members of the closed panel; therefore, be it

Resolved, That the House of Delegates of the California Medical Association define the term "free choice of physician" as that unrestricted state between patient and physician in which the patient would have absolute freedom to choose a legally qualified physician or surgeon from all of those qualified to practice who are willing to give service under the conditions established, with no reduced benefits in the event that the beneficiary is treated by a physician who is not a member of his plan; and be it further

Resolved, That selection of a physician from a closed panel group at the time of purchase of the prepayment plan, before the need for treatment of illness or injury, does not fulfill the requirements of this definition; and be it further

Resolved, That this House of Delegates approve the above definition of free choice of physician as the only one acceptable in the California Medical Association; and be it further

Resolved, That the Council of the California Medical Association is hereby instructed not to permit any California Medical Association approval, implied or otherwise, of any individual, group, or corporation dealing in medical services or insurance unless free choice of physician is exercised according to this definition; and be it further

Resolved, That the Council of the California Medical Association is hereby further instructed to use all reasonable effort to inform and instruct the public in the basic tenets of this resolution. (Applause.)

SPEAKER CHARNOCK: This is referred to Reference Committee No. 3.

DR. ROBERTSON WARD (San Francisco): Mr. Chairman, has this been asked to be an emergency?

SPEAKER CHARNOCK: It has not been so asked.

DR. ROBERTSON WARD: May I move that this become an emergency, because the one referring to this previously introduced was also on the emergency list.

SPEAKER CHARNOCK: Is there a second?

... The motion was seconded....

SPEAKER CHARNOCK: Is there any discussion?

It has been moved and seconded that this resolution be declared an emergency. Those in favor will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is accepted as an emergency and referred to Reference Committee No. 3.

DR. ALLEN HINMAN: Resolution on C.M.A.-C.P.S. Study Report:

WHEREAS, Current changes in the practice of medicine are fully recognized; and

WHEREAS, It is the responsibility of the medical profession to take the leadership in the formulation of standards of health insurance; and

WHEREAS, Because of the wealth of material and considered conclusions presented, the C.M.A.-C.P.S. Study Committee Reports should be kept fresh and vital in our minds as a source of information and as a guide in our continuing efforts to develop sound and equitable means of insurance against the cost of illness; and

WHEREAS, The objective of C.P.S. is to bring a high level of medicine to the public and also to serve as a measure for developing their methods of prepaid health insurance; and

WHEREAS, In order to obviate the necessity of any unsavory police system among us and to minimize the dissipation of insurance benefits through misuse and overuse, to broaden the accepted principle of patient-participation in meeting the cost of illness with co-insurance, particularly on a percentage basis; now, therefore, be it

Resolved, That this House of Delegates urge our Council, the Board of Trustees of California Physicians' Service, and the Medical Services Commission to use their good offices to foster and to continue the work which the C.M.A.-C.P.S. Study Committee has engendered.

SPEAKER CHARNOCK: This is referred to the C.P.S. Reference Committee.

VICE-SPEAKER BAILEY: Are there any further resolutions? Dr. Paul Foster, of Los Angeles.

DR. PAUL FOSTER (Los Angeles): This resolution is requested to be placed on the emergency basis be-

cause of the fact that the American Medical Association is going to take the subject up in about twenty days, and, therefore, they should have an expression from the California Medical Association:

WHEREAS, The practice of osteopathy has undergone a great change in the last ten or more years; thus, there are thirty states in the Union where by statute, referendum, or initiative enactment, provision has been made for full licensure of osteopathic physicians and surgeons with the same practice privileges as are enjoyed by Doctors of Medicine; there are twelve other states where there is still some limitation of practice privilege—limited to minor surgery, limited to surgery and obstetrics, limited as to the use of certain drugs, et cetera; and there are three states where an osteopath is limited to manipulation; and three states in which osteopathic practice is neither defined nor recognized; and

WHEREAS, In approximately one-half of the thirty states first mentioned above, there are two classes of osteopaths: those who obtained their licenses prior to the time that full training was required and those who obtained licenses after physicians' and surgeons' licenses became available—the former for limited licenses, no longer issued, and who ordinarily do nothing beyond manipulations; and as these, generally older, men die off, there will remain only licentiates with full practice privileges; and

WHEREAS, Standards are being raised in the colleges of osteopathy so that graduates are now generally required to take the same number of hours of premedical and medical training as are graduates of schools of medicine; and

WHEREAS, By reason of the liberalization and expansion of licensure privileges, more and more patients are being cared for by osteopathic physicians and surgeons in theoretical accordance with general medical and surgical principles; and

WHEREAS, The California Medical Association has recognized the importance, in the public interest, of enlarging the educational opportunities of the osteopathic physicians and surgeons, thus raising the standards of practice and improving the quality of medical care available to the people of California; and

WHEREAS, The House of Delegates of the California Medical Association has heretofore taken cognizance of this general problem, and, after mature consideration, concluded that the desirable ends would be attained by a rapprochement of the medical and osteopathic professions; now, therefore, be it

Resolved, That the view of the House of Delegates of the California Medical Association that the public interest would be well served by the study of possible closer coordination between the medical and osteopathic professions, is hereby reexpressed; and be it further

Resolved, That the Council of the California Medical Association and the Delegates of the California Medical Association to the House of Delegates of the American Medical Association are requested and urged to take any and all steps possible to effectuate the proposed study.

VICE-SPEAKER BAILEY: This is an emergency measure. Is there a second?

... The motion was seconded. ...

VICE-SPEAKER BAILEY: Is there any discussion? Do you wish to discuss whether this should be an emergency or not?

DR. FREDERIC P. SHIDLER: Yes, sir.

Mr. Speaker, if I am not mistaken, one year ago we instructed the Delegates of C.M.A. to the National Convention to take all possible measures to hasten the amalgamation, if you will, of the osteopathic practice and the medical practice as we now know it.

It seems to me this particular resolution is redundant, and takes up more of our time on Wednesday. I don't recall having heard any report made from our Delegates to the American Medical Association on this matter; and since we have not heard any such report, I believe a further motion to repeat last year's motion will gain us nothing until these men tell us what they did last year.

I, therefore, don't consider this an emergency.

VICE-SPEAKER BAILEY: Thank you, Dr. Shidler. There has been action on it, to be sure, but we have had no report, at least, to this House.

Is there any further discussion whether this should be an emergency?

DR. DONALD CASS: Mr. Chairman.

VICE-SPEAKER BAILEY: Dr. Cass.

DR. DONALD CASS (Los Angeles): In order to answer the previous doctor, the Past President of the American Medical Association, Dr. John Cline from California presented this to the Reference Committee at the American Medical Association, and myself and several other of our Delegates attended and discussed this subject.

I believe Dr. Askey also discussed the subject at that Reference Committee, and progress was made up to the extent of a definition of the word "cult."

Dr. Cuniffe, who is the chairman of the Judicial Council of the American Medical Association, insisted as long as he was chairman of the council, the osteopaths would be declared cultists if they insisted they had something up their sleeve the other doctors didn't have.

We ran into a stalemate there, but rumor has it now that Dr. Cuniffe has retired from his active service on the Judicial Council (laughter) and I believe Dr. Cline and Dr. Askey and the rest of our delegation plan on making another pitch back there for this, and I think that the resolution is well taken. And I wish the doctor would realize that his Delegates to the American Medical Association have really been on the job.

VICE-SPEAKER BAILEY: You are in favor of it.

DR. DONALD CASS: I am talking for it.

VICE-SPEAKER BAILEY: You are talking for backing this as an emergency?

DR DONALD CASS: Yes.

VICE-SPEAKER BAILEY: Those in favor say "aye."

... The motion was put to a vote and it was carried....

VICE-SPEAKER BAILEY: The "ayes" have it.

Dr. Garland.

DR. L. HENRY GARLAND (San Francisco): Mr. Speaker, this is a resolution on medical care for veterans, and it is being introduced now because we have the second largest collection of veterans in the country in this state, and we may very soon have the largest:

WHEREAS, It is important that medical care of the highest quality continue to be available to all veterans with service-connected disabilities; and

WHEREAS, The growing number of veterans with non-service-connected disabilities is tending to dissipate the energies of the staffs of Veterans Administration Hospitals and Regional Offices; and

WHEREAS, The care of patients with non-service connected disabilities (with the possible exceptions of mental disease and tuberculosis) is not a recognized responsibility of the Federal Government; and

WHEREAS, There are today in most communities in this country adequate medical facilities for the care of persons, both veteran and non-veteran, with civilian complaints and injuries; and

WHEREAS, The cost of providing medical care is inevitably and understandably less under local civilian auspices than under centralized federal auspices; now, therefore, be it

Resolved, That this House of Delegates respectfully petition the Congress of the United States suitably to amend the law so that on and after January 1, 1954 (or as soon thereafter as is feasible) veterans with non-service-connected disabilities shall not be eligible for care in Veterans Administration institutions; and be it further

Resolved, That copies of this resolution shall be transmitted to all other state medical associations, and to the American Medical Association, with a request for consideration and adoption of similar recommendations, recommendations which we regard to be in the long-term interest of the disabled veteran and of the taxpayer.

VICE-SPEAKER BAILEY: Dr. Garland, that is an emergency, is it?

DR. L. HENRY GARLAND: No, sir, I don't really care. (Laughter.)

I, personally, think it is an emergency, but I don't wish to take the time of this House at this time.

VICE-SPEAKER BAILEY: If you move it an emergency, it can be acted upon now. If you ask it to take effect by January 1 next, it had better be discussed before December, hadn't it?

DR. L. HENRY GARLAND: Yes, Mr. Speaker. I then wish to move this resolution be declared an emergency.

VICE-SPEAKER BAILEY: Is there a second?

... The motion was seconded....

VICE-SPEAKER BAILEY: Those in favor of making this an emergency say "aye."

... The motion was put to a vote and it was carried....

VICE-SPEAKER BAILEY: Dr. Hoffman.

DR. EUGENE HOFFMAN (Los Angeles):

WHEREAS, The American Medical Association has on two occasions memorialized the Congress of the United States to conduct a searching investigation into the inroads of the teaching of collectivism in our public school system; and

WHEREAS, A special subcommittee of the Senate is currently performing this task and has publicly exposed some startling facts concerning communism in some few of our teachers; and

WHEREAS, A special committee of the Association of American Universities has recently issued a report condemning the teaching of communism in our schools and deploring the fact that any of our teachers should be engaged in this practice, this report at the same time failing to mention the broader subject of collectivism as a whole; and

WHEREAS, Communism, while spectacular, represents only a very minor and comparatively insignificant phase of the general problem of collectivism, which, with its teachings of price and wage controls, agricultural subsidies, government housing, and a managed currency based upon an encouragement to the individual to deny responsibility for himself and to transfer that responsibility to the group, ultimately results in the regimented or totalitarian state by a process of gradualism, this ultimate result being in no manner different from that desired and achieved by the radical communist; now, therefore, be it

Resolved, That the American Medical Association is to be highly commended for its leadership in recommending this congressional investigation, and the Congress of the United States is to be similarly commended for its conduct of the investigation thus far to date; and be it further

Resolved, That a copy of this resolution be sent to the President of the United States, his Cabinet, and to every member of the Congress.

Mr. Speaker, I move this be declared an emergency.

DR. ROBERTSON WARD (San Francisco): I second the motion.

VICE-SPEAKER BAILEY: Is there any discussion on the motion whether this shall be an emergency?

All those in favor of so declaring it will say "aye."

... The motion was put to a vote....

VICE-SPEAKER BAILEY: The Chair is in doubt.

All those in favor please raise their hands.

... The motion was put to a vote by a show of hands, and it was lost....

VICE-SPEAKER BAILEY: The motion is lost. It re-

quires a two-thirds to carry. It is not an emergency.

Dr. Sloan!

DR. R. VARIAN SLOAN (Los Angeles): I wish to present this as an emergency resolution:

WHEREAS, The American College of Surgeons, through its paid spokesman, Paul Hawley, and through various of its regents and other officers, has been conducting through the pages of the public press and other media, a campaign of vilification of medicine in general by implying that all ghost surgery, unnecessary and incompetent surgery is being performed on the public by all physicians other than those who are Fellows of the American College of Surgeons or Diplomates of the American Board of Surgery; and

WHEREAS, The dignity of the profession and the confidence of the public in the medical profession has suffered immeasurably because of these intemperate and unfounded accusations by these individuals; be it

Resolved, That this House of Delegates censure these representatives of the American College of Surgeons and that a resolution be presented to the American Medical Association House of Delegates by the California delegation censuring the actions of these individuals.

I move this be considered an emergency resolution. (Applause.)

... The motion was seconded....

VICE-SPEAKER BAILEY: It has been moved and seconded this be declared an emergency resolution. Is there any discussion?

The Chair will put the question.

All those in favor of making this an emergency will say "aye."

... The motion was put to a vote and it was carried....

VICE-SPEAKER BAILEY: Dr. Rochex.

DR. FRANCIS ROCHEX (San Francisco): This is a resolution for the purpose of initiating action to improve the legal position of organized medicine:

WHEREAS, Organized medicine previously devoted its entire efforts to promote the science and art of medicine and in protecting the public health; and

WHEREAS, Medicine has lacked vision in anticipating the extent of penetration of political and socialized pressure groups; and

WHEREAS, Our inert and defensive action heretofore has encouraged these organized forces to endeavor to seize from us actual controls; and

WHEREAS, Our counter measures, hastily conceived and without purposeful organized procedure have caused us to be conciliatory, thus resulting in impaired public relations and loss of prestige in general; and

WHEREAS, There apparently now has been some abatement from government interference, the time seems to be propitious to be constructive and aggressive in action; now, therefore, be it

Resolved, That the House of Delegates approve formulation of plans that will preserve the independence of the practitioner, maintain the quality of medical care, and at the same time meet the just demand for some type of prepaid medical service; and be it further

Resolved, That the C.M.A. delegation to the A.M.A. be requested to make an effort to have legal counsel of the A.M.A. (1) review and restudy the laws (as the anti-trust laws) that hinder in any way the actions of organized medicine in endeavoring to maintain its integrity; (2) consider the feasibility of amending existing laws or sponsoring new legislation to accomplish this end.

Mr. Speaker, may I make a comment about the question of emergency resolutions?

It is my impression that this was included in our Constitution to prevent hasty action on important material presented before this House.

I do not consider this to be an emergency in the true sense of the word. However, since it envisions a long-term program, I believe that it should receive consideration at this time so that it may be acted upon at the coming meeting of the American Medical Association.

VICE-SPEAKER BAILEY: Then there is a motion to make it an emergency.

Is there a second to that?

... The motion was seconded....

VICE-SPEAKER BAILEY: Is there any discussion whether it should be an emergency or not? I hear none.

Those in favor of making it an emergency will say "aye."

The motion was put to a vote.

VICE-SPEAKER BAILEY: The Chair is again in doubt. Those in favor will raise their right hands.

... The motion was put to a vote by a show of hands and was lost....

VICE-SPEAKER BAILEY: The motion is lost. It requires two-thirds.

Dr. Leon Parker, from San Francisco.

DR. LEON PARKER (San Francisco): I am joined by Dr. Robertson Ward in this:

WHEREAS, The highest quality of medical care and rehabilitation of service-connected disabilities in veterans is an undisputed obligation of the Federal Government and a basic requirement of long-term defense; and

WHEREAS, This should be the first responsibility of the Veterans Administration medical program; and

WHEREAS, In most communities local health facilities are adequate for treatment and rehabilitation of non-service connected disabilities; and

WHEREAS, Economy is usually given as the excuse for the Veterans Administration not affording physicians in the home town program with the veterans' service medical records or records of treatment of the Veterans Administration or otherwise; and the lack of such records deters the best medical

care and rehabilitation of the veteran as well as working a hardship on the physician; and

WHEREAS, The present Veterans Administration laws state that non-service connected illnesses will be cared for by the Veterans Administration "if the individual signs an oath that he is unable to pay for private medical care"; and

WHEREAS, Such violations could be eliminated if a more accurate definition of eligible beneficiaries were defined in the law; and

WHEREAS, It is a very controversial question as to whether or not the Federal Government should continue to develop a system of socialized medicine for non-service-connected disabilities in veterans; therefore, be it

Resolved, That this House of Delegates instruct our Delegates to the American Medical Association to introduce and sponsor resolutions that will set up a program of study which will aid Congress to:

1. Continue the policy of the A.M.A. of advocating the best medical care and rehabilitation of service-connected disabilities.

2. Eliminate false economy measures in home town treatment programs and furnish the home town physician with military and Veterans Administration medical records.

3. Eliminate waste in the treatment of non-service connected disabilities, by defining a"beneficiary" sufficiently well so that the offenders could be apprehended in order to prevent the expansion of facilities for care of non-service connected disabilities.

4. Eliminate the use of Veterans' Administration hospitals as domiciliary establishments so prone to work against rehabilitation.

5. Exercise all further economy possible with the Veterans Administration to prevent the expansion of facilities for care of non-service-connected disabilities.

VICE-SPEAKER BAILEY: Is this an emergency measure?

DR. LEON PARKER: No.

DR. ROBERTSON WARD: May I move that this be an emergency measure, because this is to carry out exactly the same thing, as I see it, as Dr. Garland's, and if one is given consideration before this Reference Committee, the other ought to also be given consideration.

I move this be an emergency.

... The motion was seconded. ...

VICE-SPEAKER BAILEY: It has been moved and seconded that this be declared an emergency. Is there any discussion?

All those in favor signify by saying "aye."

... The motion was put to a vote and it was carried. ...

VICE-SPEAKER BAILEY: Neither Dr. Charnock nor I are happy about this emergency business. Time was when a man could bring an emergency resolution before the House, and it required nothing more than it be submitted to the Reference Committee.

If you recognize it now, it is perfectly clear that some of these things have not been declared an emergency. They can be resubmitted and go to the Reference Committee after the proper time.

I call that to the attention of the few men who have brought these resolutions that have not been declared emergencies.

Dr. Albert G. Miller.

DR. ALBERT G. MILLER (San Mateo):

WHEREAS, Many issues and policies affecting us are being made by national law and international agreements; and

WHEREAS, The practice of medicine may be affected economically and in a broad scientific sense; and

WHEREAS, We are always vulnerable to attempts of collectivism through legislative channels; and

WHEREAS, Our medical societies have contained themselves too long and should now assume the offense on these matters; now, therefore, be it

Resolved, That our Delegates to the A.M.A. alert the A.M.A. House of Delegates to this particular problem, and specifically be it further

Resolved, That we and our Delegates to the A.M.A. heartily endorse and urge every member of Congress to adopt Senate Joint Resolution No. 1, the so-called Bricker Resolution.

Mr. Speaker, because of the impending legislation on this particular bill in the Senate, I would like to ask the members of this House to go along with my motion to make this an emergency, in spite of all the many issues you have before you. I would like to still make that request, and put that in the form of a motion, that it be an emergency.

VICE-SPEAKER BAILEY: Is there a second?

... The motion was seconded. ...

VICE-SPEAKER BAILEY: Is there any discussion?

A MEMBER: A point of information. What is the Bricker Resolution?

VICE-SPEAKER BAILEY: What is the Bricker Resolution?

DR. ALBERT G. MILLER: I could tell you, but I would like to turn it over to somebody who knows a little more than I do. I would like permission to ask Dr. Alesen to speak on it.

VICE-SPEAKER BAILEY: Dr. Alesen, will you speak on that?

PRESIDENT L. A. ALESEN: Mr. Speaker, members of the House: I very strongly recommend that this be made an emergency resolution.

As you know, we have had the examples of Teheran, Potsdam, and Yalta, executive agreements made above and beyond the control of our Congress, which have become the law of the land.

The Sixth Article of the Constitution of the United States provides that anything adopted by treaty with a foreign power shall always take precedence over any domestic law.

Now, the Senate Joint Resolution No. 1 proposed by Senator Bricker merely results from the pro-

posals made by the House of Delegates of the American Bar Association, working in connection with men like Frank E. Holman and Dean Manion, who, by the way, is to speak to us on Tuesday evening.

The purpose of the Bricker Resolution is to amend Article VI of the Constitution that, first of all, any treaty made with a foreign power which in any manner interferes with our Constitution shall be invalid as to that specific provision. Secondly, that no treaty made with a foreign power shall in any manner interfere with our domestic law, except upon congressional legislation. And third, executive agreements shall be subjected to the same requirements as our treaties and congressional legislation.

Now, let's see a moment, Mr. Speaker, if I may elaborate a little bit. You recall some two or three years ago there was a determination made by our Appellate Court here in California on the case of Fuji versus California. This was an appeal by a Japanese who wanted to own land and was denied the right to own land because of our alien restrictions.

The Appellate Court held that because the United States was and is a signatory to the United Nations, and because of an action of the United Nations General Assembly opposing any racial restrictions in member nations with respect to the ownership of property, therefore, the rights of you and me as citizens of California to determine who shall and who shall not own land, had been abrogated.

Now, Mr. Speaker, I won't stand before you and discuss pro or con whether or not any individual or race should be restricted with respect to ownership of land. I, personally, think the Japanese people ought to own land, but nonetheless I contend that the determination upon that proposition should be made by you and me as citizens of the State of California, and not by some super-organization over which we have no control whatsoever.

There are several other instances which I think should be elaborated. Perhaps Mr. Hassard would like to do so. But here is the purpose, and I call your attention specifically to this: The International Labor Organization which was organized in 1920, and of which we in the United States have been members since 1935, did in June 1952 draw up some nine rather elaborate proposals for socialization among member nations, about three of which provided an elaborate code for socialized medicine.

Now, just what could happen? That so-called convention of the International Labor Organization was referred to and is at this time before the Finance Committee of the Senate of your land and mine. Only a majority of seven out of the thirteen votes would be required to move that resolution, that convention onto the floor of the Senate.

The law requires merely a two-thirds majority of those Senators present and voting, and only a handful of Senators could adopt the International Labor Organization convention which, in turn, would bring socialized medicine to every one of us in America without the subject ever having been discussed by the Congress of the United States.

Now, the Bricker Resolution following the proposals of the American Bar Association, merely proposes, as I said a while ago, to return to America the rights to make its own legislative determination.

Please, ladies and gentlemen of the House of Delegates, this is your land and mine. Let's do something about freedom. (Applause.)

VICE-SPEAKER BAILEY: Thank you, Dr. Alesen. Dr. Alesen is in favor of the emergency resolution. (Laughter.)

Any further discussion on the point of whether this is an emergency or not? Hearing none, the Chair asks those in favor to say "aye."

... The motion was put to a vote and it was carried....

DR. HENRY GIBBONS III (San Francisco): On behalf of the Medical Services Commission, I will introduce this amendment to Chapter VII of the By-Laws of the C.M.A., adding a new Section 21, relating to the Medical Services Commission:

Resolved, That Section 21 is hereby added to Chapter VII of the By-Laws of this Association, to read as follows:

"Section 21—Medical Services Commission.

(a) The Medical Services Commission shall consist of nine members appointed by the President, with the approval of the Council, for three-year terms, with three members to be appointed each year.

(b) There shall be a chairman, vice-chairman, and secretary of the Commission, each of whom shall be appointed each year from amongst the membership of the Commission by the President of the Association, with the approval of the Council.

(c) There shall be an Executive Committee of the Commission, consisting of the officers. The Executive Committee shall meet at the call of the chairman, and shall perform such duties and exercise such powers as the Commission may direct.

(d) The Medical Services Commission may study all matters relating to the problems of organized medical services or hospital care, and shall from time to time submit recommendations thereon to the Council. In addition, it shall perform such other duties as the Council may delegate to it. It should provide a liaison with all public and private groups that are interested in the field of organized medical services, and should be available to the component societies and organizations affiliated with or related to this Association for consultation and advice. The Commission may, from time to time, appoint special study committees from amongst the membership of the Association to study specific assigned problems and to report findings and recommendations to the Commission.

(e) The Commission shall meet at the call of its chairman, and a majority of the members of the Commission shall constitute a quorum."

Be it further

Resolved, That the present Sections 21 and 22 of

said Chapter VII are renumbered 22 and 23, respectively.

VICE-SPEAKER BAILEY: That will be referred to Reference Committee No. 4, and will automatically be taken up on Wednesday.

All the previous ones have been referred to No. 3, but this is on the By-Laws.

Are there any further resolutions?

Dr. Rochex?

DR. FRANCIS ROCHEX: I wish to resubmit the resolution I read a few moments ago. I shall not reread it. Its purpose is to initiate action to improve the legal position of organized medicine.

VICE-SPEAKER BAILEY: Thank you, Dr. Rochex.

That, then, is accepted and referred to Reference Committee No. 3.

Dr. Craig, do you have something?

DR. LYLE G. CRAIG (Los Angeles): I believe under the regulations I can resubmit that resolution. Do you have a copy of it?

VICE-SPEAKER BAILEY: That is all right. We know what it is.

DR. LYLE G. CRAIG: It is the one about asking the American Medical Association to be more strict in the selection of advertising material from pharmaceutical firms.

VICE-SPEAKER BAILEY: It is resubmitted.

Are there any further resubmitted resolutions?

Dr. Hoffman would like to do the same. Unless anyone wants to object to it, we will have Dr. Hoffman's resubmitted and referred to Committee No. 3.

Now, Dr. Charnock.

SPEAKER CHARNOCK: Is there any more new business to come before this session? If not, we have a couple of announcements to make.

. . . Announcements. . . .

SPEAKER CHARNOCK: Our Legal Counsel, Hap Hassard, has something to say on the Interim Session.

MR. HOWARD HASSARD: There are two By-Law amendments that were introduced today that, if either one is adopted, will affect the future holding of an Interim Session.

There are possibilities of confusion on Wednesday unless all of the resolutions introduced today, whether designated as emergency or not, are heard by the Reference Committees to which each has been referred, so that each Reference Committee is prepared to report on everything referred to it, depending on what this House decides to do.

Therefore, may I suggest that each Reference Committee consider all resolutions that have been referred to it, and that each member of the House who is interested in any resolution appear before the appropriate Reference Committee Wednesday, and then, depending on what you do on Wednesday, you may or may not be called upon to consider the few resolutions that weren't of an emergency nature.

SPEAKER CHARNOCK: It has been recommended that we have a show of hands by those who do or do not want an Interim Session. Let's make it easy and say that those who do not want an Interim Session, put up their hands.

. . . A show of hands. . . .

SPEAKER CHARNOCK: Now, those who would like to have an Interim Session.

. . . A show of hands. . . .

DR. LESLIE MAGOON (Santa Clara County): Mr. Speaker, I should like to differ with Mr. Hassard's opinion in one respect.

I should like to differ with Legal Counsel. As I heard each amendment, each one specified that under the circumstances this Interim Session cannot be eliminated by the adoption of either version.

SPEAKER CHARNOCK: Would Legal Counsel like to carry on this debate?

MR. HOWARD HASSARD: One of the proposals that was introduced by Dr. Kirchner is exactly as Dr. Magoon just stated. It calls for the continuance of the Interim Session, unless in a given year it is decided not to hold it. The other By-Law amendment introduced by Dr. Hinman of San Francisco, is in the reverse. It calls for the elimination of the Interim Session unless it is decided to hold it. It also calls for that decision to be made as the first order of business by the House of Delegates at the regular session.

Well, if you adopt that one on Wednesday, it will be too late to make the decision for this coming December, and I am trying to avoid an argument on Wednesday, merely by asking the Reference Committees and the members of the House of Delegates to be prepared on everything that has been introduced.

Those that are not an emergency, you may not be called upon to consider on Wednesday, but, at least, like Boy Scouts, you can "be prepared." (Laughter.)

SPEAKER CHARNOCK: It is nice to have somebody do your arguing for you.

If there is no further business to come before this body, we will recess until 9:30 a.m. on Wednesday, May 27, in this room.

. . . The Session adjourned at 4:30 p.m. . . .

Wednesday Morning Session

The Wednesday morning session of the California Medical Association, House of Delegates, was called to order in the Renaissance Room at 9:30 a.m. by Speaker Donald A. Charnock, who presided.

SPEAKER CHARNOCK: Our General Session meeting will please be in order, and we will have the report from Dr. Hoffman, chairman of the Credentials Committee.

DR. HOFFMAN: Mr. Speaker, there is a quorum present. As chairman of your committee, I move that the visual roll call be accepted in lieu of the usual roll call.

SPEAKER CHARNOCK: Is there a second to that motion?

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded the visual roll call be accepted instead of the oral roll call. Is there any discussion?

... The question was called for, the motion was put to a vote and it was carried....

SPEAKER CHARNOCK: The House is in session.

DR. HOFFMAN: Mr. Speaker, may I make an announcement?

... Announcements....

SPEAKER CHARNOCK: This little book of ballots, we hope, will save a little time, and every delegate who is entitled to vote, is entitled to a book of ballots. If you do not have it, ask Dr. Hoffman.

... Announcements....

SPEAKER CHARNOCK: The next order of business is an announcement by the Secretary, Dr. Daniels.

SECRETARY ALBERT C. DANIELS: This morning, the Council considered where to hold the next Annual Session, and a motion duly made, seconded and carried, was that we hold our 1954 Session at the Biltmore Hotel in Los Angeles, and that the 1955 Annual Session is to be held in San Francisco.

ELECTION OF OFFICERS

SPEAKER CHARNOCK: The next order of business is the election of officers. The first office is that of President-Elect. The Chair will accept nominations for the office of President-Elect.

DR. SAM J. MCCLENDON (San Diego): Mr. Speaker, Mr. President-Elect, officers of the California Medical Association, fellow delegates: This morning, it is a rare privilege for me to appear before you to place in nomination one of your members.

The member I would like to place in nomination was born in Nebraska of good, hearty American heritage. He was educated in the public schools of Nebraska. He graduated in medicine from Creighton University.

He came to California twenty-nine years ago. He has been practicing in San Bernardino County ever since. He has occupied every position of honor and trust in his county medical society, including one term as president of that organization.

He has served as a delegate to this body for twelve years. He was a member of our Council of the C.M.A. for two terms. He is an honorable practitioner of medicine. He has had the interest of the California Medical Association at heart all of his life. He is honest, and his integrity is unquestioned, and I know that he deserves the honor and will serve in this capacity as those who have gone before him have served honorably and well.

I would like to place in nomination the name of Dr. Walter Cherry of San Bernardino. (Applause.)

SPEAKER CHARNOCK: Dr. Cherry's name has been placed in nomination.

DR. SAMUEL R. SHERMAN (San Francisco): Mr. Speaker, members of the House of Delegates: It is an even rarer privilege for me to be before you today to follow the illustrious Sam McClendon to second the nomination of Walter Cherry for President-Elect of the California Medical Society.

I have met Dr. Cherry for the first time this year, and like a great many delegates in my San Francisco Medical Society, I have been most markedly impressed by his sincerity and with his qualifications for this job.

I feel that it is an honor to second the nomination of a man who, in my estimation, is a fine physician, an excellent American citizen, a wonderful father, and who will make an outstanding representative for all of us in the California Medical Association.

Thank you. (Applause.)

SPEAKER CHARNOCK: Dr. Ruddock, of Los Angeles County.

DR. JOHN C. RUDDOCK (Los Angeles County): Mr. Speaker, members of the House: The highest honor you can give a man of this association is to be its president. It is an honor we should give a man for years of practice; an honor we should give a man of years of service to organized medicine.

Such a man is the candidate Dr. Walter Cherry. I believe he is over fifty years of age. I think we need the counsel of a man with a few gray hairs in his head. I think this is a precedent that has been followed by many organizations for many years.

So, at this time, I would like to place before you my friend of many years, Dr. Walter Cherry. (Applause.)

DR. R. STANLEY KNEESHAW (Santa Clara County): Mr. Speaker and members of the House of Delegates: I, too, want to second the nomination of Walter Cherry. I have known him for many years. I know how intelligent and friendly he is, and how well he would represent this society should we elect him as President.

I have had the honor of being one of the Presidents of this Association, and I know how much there is in being elected to that office. I certainly did appreciate the honor that I had, and I am sure that it is an honor for anybody to have it, and I know that he will fill that position well should he be elected.

I would like to second the nomination. (Applause.)

DR. R. VARIAN SLOAN (Los Angeles): I, too, would like to second the nomination of Walter Cherry as President-Elect of the California Medical Association.

I have known Dr. Cherry ever since I was an intern. In fact, he was my senior staff man out at San Bernardino when I was an intern in that county hospital. No one on the staff was more highly honored than Walter Cherry, and I feel it a privilege and an honor to be able to second his nomination. (Applause.)

DR. ROGER A. VARGAS (San Bernardino County): Mr. Speaker, members of the House: It is with a

great deal of pride that I come before you on this occasion as representative of the San Bernardino County Medical Society of which Dr. Walter Cherry has been a member for the past twenty-nine years.

It has been my pleasure and privilege to become closely acquainted with Dr. Cherry.

He has been most active in all of the affairs of our own society, and because of this was honored by being elected president of the society.

He has been most active in civic affairs, and because of this fact realized it was necessary for him to participate fully in the affairs of the California Medical Association.

As a result of his activities within his own society and within his own city, he was named to the Council of the California Medical Association in 1945. He was active as a member of the Council for several years, relinquishing the position only to allow an urgent replacement.

He continued to take an active part in all of the affairs connected with his community and with medical practice.

He gave counsel to his successors whenever problems of the county medical society had to be solved.

Because of his background as a general practitioner in a small community, he has been aware of the trends and thoughts of the people. He has been able to discuss openly and frankly any and all problems concerned with medical practice, and as a result has been able to grasp the meaning of medical services to the patient at the grass roots level.

With this experience and background, it is quite evident he has developed the philosophy of service to the people which stands at the very source of medical practice. He is in a position to continue to lead the members of the California Medical Association in an era of service to the patient, of understanding of the problems confronting medicine today.

Here is a man who has devoted many years of service to his community, to his patients, to fellow practitioners, to the county medical society, and to the state society.

Here is a man who by training has become a logical leader of his state society. Here is a man able and willing to devote all of the time necessary to the problems confronting medicine in the State of California.

Therefore, Mr. Speaker and members of the House of Delegates, I have the honor to second the nomination for President-Elect of the California Medical Association of Dr. Walter Cherry. (Applause.)

DR. J. J. CRANE (Los Angeles County): I wish also to second the nomination of Walter Cherry for President-Elect and I feel that we should choose the man, all things being equal, who has been the longest in the service of our organization.

Now, if we will stay by that right straight through, we will make no mistakes in this organization, and I believe if you will look back on history, you will find that that has been our policy, and it should continue to be our policy. (Applause).

SPEAKER CHARNOCK: Are there any more seconds?

Are there any more nominations for the office of President-Elect?

Dr. Moore.

DR. J. W. MOORE (Ventura County): Mr. Speaker, members of the House of Delegates: I feel privileged and greatly honored to be able to place before you in nomination for the office of President-Elect of the California Medical Association the name of a man from the County of Ventura. The last and only time in the past that the Ventura County Society had this honor was in 1897 when Dr. Cephas L. Bard was nominated and elected to the office of President of the California Medical Society.

As evidence of the fact that times have changed since then, the total membership of the Association at that time was some three hundred. We are now more than eleven thousand.

The problems facing our profession have multiplied in proportion. Likewise, the demands upon our executive officers in time, energy, and effort have similarly multiplied.

Organized medicine is in a difficult phase of its existence. The California Medical Association has, for many years, been a leader in organized medicine, and it remains vigorous and active. It is essential to each and every one of us that it continue so.

We require as an executive, a man who can provide us with diligent, vigorous, active and aggressive leadership.

I have the honor to present such a man in nomination for this office, and I would like to tell you of some of his qualifications for it.

Dr. A. A. Morrison is forty-eight years of age. He was first elected as a delegate to this House in 1934; nineteen years ago.

He served continuously in it until 1951, except for the time he was occupied serving our country in the last war.

He was also secretary of the Ventura County Medical Society from 1934 to 1951, except for his war years.

During this time he served actively in the House of Delegates, and was a member of many committees.

In 1951 Dr. Morrison was elected to the Council of the C.M.A. and has served there to the present time.

He was appointed to the Board of Trustees of C.P.S. one year ago, and is now a member of that Board.

He has also been a member of the Council of the California Public Health League for the past six years. He has never been absent from a meeting of the C.P.S. Board or the C.M.A. Council since assuming his duties.

His association in our affairs has been long and continuous, and he has never been found wanting in any duty given him.

Dr. Morrison served in the United States Navy from January 1941 to October 1945. He reverted to

inactive duty with the rank of captain. He has been active in civic affairs of every variety from membership on school trustee boards to membership in the Red Cross.

He has been a member of the board of directors of Tri-Counties Blood Bank for the past several years and he was active in initiating and establishing that blood bank.

I could enumerate many other of his activities and accomplishments, but this is enough, I am sure, to reveal to you what type of a man he is.

He has proven his ability, his energy, his faithfulness, and his integrity over and over again. His experience in our Association affairs has been continuous and long. His qualifications for the office of President-Elect are unquestioned. He has the youth, the experience, the energy, to provide us with great leadership.

It is my pleasure and honor to place in nomination for President-Elect of the California Medical Association the name of Dr. A. A. Morrison. (Applause.)

SPEAKER CHARNOCK: Dr. A. A. Morrison has been placed in nomination for President-Elect.

Francis Hodges, of San Francisco County.

DR. FRANCIS HODGES (San Francisco County): Mr. Speaker and delegates: It has been my good fortune during the last year to assess the worth of Dr. A. A. Morrison. He brought to the Board of Trustees of C.P.S. his wisdom, experience, and gift of analysis. I am certain that he received a good part of his quota of gray hairs on that Board; and he has the gray hairs, I can assure you.

We trustees sought and valued his opinions, as I am sure C.M.A. will continue to seek and value his opinions.

It is, therefore, my happy office to second the nomination of Dr. A. A. Morrison. (Applause.)

SPEAKER CHARNOCK: Dr. David Dozier of Sacramento County.

DR. DAVID DOZIER: (Sacramento County): It is my great pleasure to second the nomination of Dr. Morrison for President-Elect.

You know, there is an old rule that says a man's true stature is in the reverse proportion to the personal pronouns straight up. The bigger the "I," the more a man speaks of his own accomplishments, often the less the true ability of the man.

Certainly, I would say in relation to Dr. Morrison, he is quiet and soft-spoken. Those who have worked about him say he has very little to say, but he is a great doer.

I believe that if we think of that simple rule, here is a man who has really done some grass roots public relations and service for our medical society.

Those who have worked close to him, those who have been about him, can ardently testify to the very fine character of the work he has done.

I think he is a man eminently qualified for the position, and it is my pleasure to second the nomination. (Applause.)

DR. H. GORDON MACLEAN: Mr. Speaker, members of the House of Delegates: I take great pleasure in seconding the nomination of Dr. Morrison. I have had the opportunity as a member of the Council and later as President-Elect and President, of observing Dr. Morrison's work. On the Council he is not a noisy man. He is a quiet thinker, but he expresses himself very well indeed, and he has given every indication of great strength.

I also had the pleasure of going around with him on some of our tours when we were visiting county medical associations. I assure you Dr. Morrison carried out his part of these tours very well indeed, and I believe he has done a great deal in unifying the counties for which he has been their Councilor.

I, therefore, wish to recommend to you Dr. Morrison, and I am sure, should you elect him to this position, you will find the office taken care of by very strong, capable hands. (Applause.)

SPEAKER CHARNOCK: Are there any other nominations for President-Elect?

The Chair, hearing none, declares the nominations closed. They are closed.

We will appoint as tellers Philip Baxter of Alameda, Verne Ghormley of Fresno, Wells C. Cook of Los Angeles, Allan Hinman of San Francisco, Leon Fox of Santa Clara, and J. B. Price of Orange.

If these gentlemen will collect the ballots and bring them up and count them, please. This will be Ballot No. 1.

I think it would be very nice if we asked the two gentlemen who are running for this office to stand.

Dr. Walter Cherry, stand, please. (Applause.)

Dr. A. A. Morrison, will you stand. (Applause.)

We are balloting on Ballot No. 1.

VICE-SPEAKER BAILEY: If there are no objections, we shall continue with the program while the tellers are collecting the votes. I hear no objections.

The next office is that of Speaker.

Are there any nominations for Speaker of this Association?

DR. EWING L. TURNER (Los Angeles): Mr. Chairman, members of the House: It is really a great honor and a great privilege for me to place in nomination today the name of one of my good friends, the name of a man who is a good friend of all State Medical Association activities, a man whom all of you know and know very well because of the excellent work he has done in the House of Delegates for the past two years.

Don Charnock, as you know, was graduated from Harvard Medical School in 1925, came to Los Angeles and has been actively engaged in practice here since that time.

He has always been extremely generous with his time to Association activities, and I think it is unnecessary for me to tell you gentlemen in the House how well he has performed for the past two terms as Speaker of the House.

I am sure that all of you have noticed a streamlining, modernizing of procedures in making this House run smoothly.

The visual roll call, for example, has eliminated

about an hour and a half of routine here at the opening of each of these House of Delegates meetings.

So, because this is a man who has the interest of all of us at heart, because he is a man who really loves medicine, it is with a great honor that I place in nomination for Speaker of the House to succeed himself, Dr. Don Charnock. (Applause.)

VICE-SPEAKER BAILEY: Dr. Charnock has been nominated. Are there further nominations? Are there any further nominations?

The Chair hears none.

A MEMBER: I move they be closed.

VICE-SPEAKER BAILEY: The Chair declares the nominations closed. How will you vote?

... There were calls of "acclamation." ...

VICE-SPEAKER BAILEY: All those in favor of electing Dr. Charnock will say "aye."

... The motion was put to a vote and it was unanimously carried. ...

(Applause.)

SPEAKER CHARNOCK: Thank you very much, ladies and gentlemen.

The next order of business is the election of a Vice-Speaker.

DR. EUGENE HOFFMAN (Los Angeles County): Mr. Speaker and members of the House of Delegates: It is my privilege to place in nomination for Vice-Speaker, Dr. Wilbur Bailey. You have seen how he has conducted himself, and you have seen what a fine team he makes with our again newly-elected Speaker.

Thank you, ladies and gentlemen.

SPEAKER CHARNOCK: Are there any other nominations for the office of Vice-Speaker?

The Chair hearing none declares the nominations closed. They are closed, and Dr. Bailey is elected. (Applause.)

For the record, we should say, "Those who are in favor of Dr. Bailey's election signify by saying 'aye.' "

... The motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: He is unanimously elected.

I don't want to streamline this too much. (Laughter.)

The next order of business is the election of District Councilors.

I will remind you that the District Councilors are nominated by the delegates from their districts.

Their districts should have reported them to the Chair before now, but they have not.

We will call on the Second District for its nomination.

DR. FRANKLIN B. MEAD (Riverside County): Mr. Speaker and members of the House: The Second District has met in caucus. We wish to place in nomination to succeed himself Dr. Omer W. Wheeler.

SPEAKER CHARNOCK: The name of Dr. Omer W. Wheeler has been placed in nomination by the delegates from the Second District. Is there any challenge from the House? The Chair hearing none, declares Dr. Wheeler elected. (Applause.)

The Eighth District, San Francisco.

DR. ALLEN T. HINMAN (San Francisco): According to Chapter VIII, Section 6 of the By-Laws of the California Medical Association, the delegates from San Francisco, the Eighth District, have elected by unanimous vote, on May 24, Dr. Sidney Shipman as Councilor for this district. (Applause.)

SPEAKER CHARNOCK: The name of Dr. Sidney J. Shipman has been placed in nomination by the Eighth District. Do we hear any challenge from the House? Hearing none, the Chair declares Dr. Sidney Shipman elected from the Eighth District. (Applause.)

The Eleventh District. Dr. Dave Dozier.

DR. DAVE DOZIER (Sacramento County): The Sacramento Society for Medical Improvement, sir (laughter), the Eleventh District, takes great pleasure in nominating Dr. Ralph Teall from the Eleventh District. (Applause.)

SPEAKER CHARNOCK: Dr. Ralph Teall has been nominated by the Delegates from the Eleventh District.

Is there any challenge from the floor? The Chair hearing none, declares Dr. Ralph Teall elected. (Applause.)

We will now have nominations for Councilors-at-Large.

Two offices are open, Sidney J. Shipman, San Francisco, term expiring, and Arthur A. Kirchner, Los Angeles, term expiring.

These nominations come from the floor.

DR. SIDNEY J. SHIPMAN: Mr. Speaker, may I be heard?

SPEAKER CHARNOCK: Dr. Sidney Shipman, Councilor from the Eighth District.

DR. SIDNEY J. SHIPMAN: Members of the House: It has been interesting to me to watch from time to time the rising influence of certain societies, and I think Alameda-Contra Costa is due recognition at the present time.

You realize that Alameda-Contra Costa County is now known for its recent accomplishments, not only in the State of California, but throughout the nation.

That means to me that this county has excellent leadership.

One of those leaders has been Dr. Eric Reynolds as most of you in this House know. He is a graduate of the University of California Medical School. I trust you won't hold that against him. (Laughter.)

He is a general practitioner. He is a member of the American College of Surgeons. He was president of the Alameda County Medical Society in 1950, a member of the Board of Trustees of C.P.S. for four years; one of the organizers of Northern Blue Cross, a member of the House of Delegates for many years,

and the president of the medical staff of Alta Bates Hospital.

Incidentally, he was in the United States Navy for four years.

It is an honor and privilege for me to place in nomination the name of T. Eric Reynolds of Oakland. (Applause.)

SPEAKER CHARNOCK: The name of Dr. T. Eric Reynolds has been placed in nomination for Councilor-at-Large, for the northern group.

Are there any other nominations for this office?

A MEMBER: I move the nominations be closed.

... The motion was seconded. ...

SPEAKER CHARNOCK: It has been moved and seconded that nominations for this office be closed.

How will you vote?

... There were calls of "by acclamation." ...

SPEAKER CHARNOCK: Those who are in favor of Dr. T. Eric Reynolds for Councilor-at-Large will signify by saying "aye."

... The motion was put to a vote and it was carried. ...

SPEAKER CHARNOCK: He is elected. (Applause.)

Now for the office of Dr. Kirchner, term expiring.

DR. J. PHILIP SAMPSON: Mr. Chairman, members of the House of Delegates: It is my privilege to nominate Arthur to succeed himself.

Art has been a member of this group for a year. He has been on one committee, has done a tremendous amount of work. He is a hard-working man. I am sure all the men who have worked with him know him as an honest and capable man.

In one year you can barely get your teeth in the job. We need a man for many years on the Council.

It is my privilege to again nominate Arthur Kirchner to succeed himself. (Applause.)

SPEAKER CHARNOCK: Art Kirchner has been nominated to succeed himself. Are there any other nominations?

The Chair, hearing none, declares the nominations closed. They are closed.

How will you vote?

... There were calls of "by acclamation." ...

SPEAKER CHARNOCK: Those who are in favor of Arthur Kirchner of Los Angeles County will please signify by saying "aye."

... The motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: Dr. Arthur Kirchner is declared elected. (Applause.)

VICE-SPEAKER BAILEY: We have the election results here.

SPEAKER CHARNOCK: The Secretary will read the announcement of the election for President-Elect.

SECRETARY DANIELS: Dr. Morrison received 138 votes, and Dr. Cherry 92.

Dr. Morrison is elected. (Applause.)

SPEAKER CHARNOCK: Dr. Morrison has been elected. (Applause.)

Dr. MacLean, Dr. Kneeshaw, Dr. Peers, will you bring our new President-Elect to the rostrum? (Standing applause.)

We are very happy to have Dr. Peers, Past President, with us this morning for this little task. (Applause.)

Now we will go to the Fifth District. Nominations are now in order for Councilor from the Fifth District.

Dr. Moore of Ventura.

DR. J. W. MOORE (Ventura County): Mr. Speaker, members of the House of Delegates: The Delegates from the Fifth District, Ventura, Santa Barbara and San Luis Obispo, met in caucus and elected to place before you the name of Dr. Robert O. Pearman from San Luis Obispo as Councilor from the Fifth District.

SPEAKER CHARNOCK: The name of Dr. Robert O. Pearman has been placed in nomination by the Delegates from the Fifth District.

Is there any challenge to the name of Dr. Robert O. Pearman?

The Chair hearing none, declares him elected Councilor from the Fifth District. (Applause.)

VICE-SPEAKER BAILEY: The next order of business is the election of Delegates to the American Medical Association; Robertson Ward, San Francisco, term expiring.

Are there any nominations to this office?

DR. DONALD M. CAMPBELL (San Francisco): Mr. Speaker, fellow delegates: Someone said some time ago to listen not to him that flattered with lips. So, I hope the remarks I make subsequently will not be considered as such.

The individual that I wish to nominate today comes from a Scotch-Irish, English ancestry, and I must admit that he doesn't talk too freely about his English ancestry, but he stresses more the Irish and the Scotch lineage.

Of course, his wit and acuteness in politics apparently come from his Irish ancestry. But, of course, his general broad judgment, I am convinced, comes from a race that my ancestors formerly belonged to. (Laughter.)

The greatest fight for freedom that this world has ever seen, and possibly the first time that freedom was ever released was fought almost 639 years ago at the Battle of Bannockburn, when Robert Bruce, after learning all his tactics of war from Edward the Second, was suspected as not being loyal to him and slipped away one night by moonlight and arrived over the Scotch border. You know the result. In 1314, on June 24, the English army numbering but 100,000 men was completely defeated by Robert Bruce.

But, before the battle started he was seated on a small, light, fast-moving horse without armor, and Henry Bowen was the advance guard of the English. He saw his chance to eliminate the fight, and immediately dashed forth with his heavy armor, but the old Scot saw his chance and ended for all time Sir Henry's career.

However, in so doing he broke his famous battle axe's handle.

I don't know whether you people have ever used an axe like I have. You are possibly using it now in a different method, but if you use an axe for a certain time, the handle is so warped that it fits the individual.

In my former days in a contest in the far North, when I was on a river driving job, in order to win the contest, if you were right-handed, they would hand you a left-handed axe, and if you were left-handed they would give you a right-handed axe. With such an axe, you find out you miss by two or three inches.

Robert Bruce bemoaned all afternoon that he had ruined such an axe on so unworthy a head.

Now, you all know this man. His ancestor fought at the Battle of Bannockburn and before the horrible English charge.

Before that initial impact, the sub-commander of the Black Douglas yelled at the top of his voice, "Stand fast."

I don't wish to mention his name because I will mention it later. (Laughter.)

Now, this individual from San Francisco is a personal friend of mine. He has been through practically every office in the society. He uses balance, he uses judgment.

I have had my personal difficulties with him, and anyone who has sat on the Board of Directors of this society up there realizes you have to give and take.

Throughout his career he has given a great deal of his time to medicine, while some of us sat back and loitered. He has represented us in the society from all angles.

He has represented us for four, almost five years as a Delegate to the American Medical Association.

I wish to place in nomination my good friend Robertson Ward. (Laughter.)

VICE-SPEAKER BAILEY: Any other nominations besides Robert Bruce here — I mean Robertson Ward?

Are there any further nominations for this office?

The Chair hearing none, declares the nominations closed.

How will you vote?

... There were calls of "by acclamation." ...

VICE-SPEAKER BAILEY: Those who are in favor of electing Dr. Robertson Ward will say "aye."

... The motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: Dr. Robertson Ward is declared elected.

DR. ROBERTSON WARD: Thank you, gentlemen. (Applause.)

VICE-SPEAKER BAILEY: The next office is that of Dr. Sam J. McClendon, San Diego, term expiring.

DR. JOHN M. RUMSEY (San Diego County): You know, the Scotch seem to be very popular here this morning. Maybe it is what we have been drinking the last three days.

The man I wish to place in nomination to succeed himself is one of the hardest workers that the Medical Association of California and of America has ever had. Sam has worked long and hard. He has done a good job. He has always produced. All of the reports from the American Medical Association are glorious in his deeds.

I would like to nominate Sam McClendon to succeed himself. (Applause.)

VICE-SPEAKER BAILEY: Dr. Sam J. McClendon has been nominated to succeed himself. Are there further nominations? Hearing none, the Chair declares the nominations closed.

Will you vote by acclamation?

Those in favor say "aye."

... The motion was put to a vote and it was carried. ...

VICE-SPEAKER BAILEY: Dr. McClendon is declared elected. (Applause.)

Next is Dr. Eugene F. Hoffman, Los Angeles, term expiring.

Dr. Wadsworth, from Los Angeles.

DR. E. E. WADSWORTH (Los Angeles): Mr. Speaker: As has been the policy of this House for many years, and reasonably so, to return men who have done a good job to our delegations, I would like to nominate Eugene Hoffman to suceed himself. (Applause.)

VICE-SPEAKER BAILEY: Are there further nominations? Are there any other nominations?

The Chair hearing none, declares the nominations closed.

Voting by acclamation, all those in favor will say "aye."

... The motion was put to a vote and it was carried. ...

VICE-SPEAKER BAILEY: Dr. Hoffman is elected.

Next is Dr. John W. Green, Vallejo, term expiring.

DR. L. H. FRASER (Alameda-Contra Costa County): The man I wish to nominate is getting a little old, but he is young enough to serve as your President next year. He served seventeen years as a delegate. It is my honor to present the name of Dr. John Green. (Applause.)

VICE-SPEAKER BAILEY: Dr. John Green.

Are there further nominations for this office?

Nominations are closed.

Those in favor of Dr. Green will say "aye."

... The motion was put to a vote and it was carried. ...

VICE-SPEAKER BAILEY: Dr. Green is elected.

Dr. Lewis A. Alesen, Los Angeles, term expiring.

Dr. Quinn.

DR. WILLIAM F. QUINN (Los Angeles): As an Irishman, I would like to nominate a Norwegian. (Laughter.)

I might say this about Lewie. Anyone smart enough to talk me into two-to-one odds on the Civic Auditorium, and I owe him two bottles of Scotch

this morning, is smart enough to take care of our interests.

I, therefore, nominate Lewie Alesen to succeed himself. (Laughter and applause.)

VICE-SPEAKER BAILEY: Dr. Alesen has been nominated.

Are there any further nominations?

The Chair declares the nominations closed.

Those in favor of electing Dr. Alesen will say "aye."

... The motion was put to a vote and it was unanimously carried....

VICE-SPEAKER BAILEY: Dr. Alesen is elected.

Frank A. MacDonald, Sacramento, term expiring.

DR. DAN KILROY (Sacramento): As the oldest Society in California, we have never apologized to the House of Delegates. I wish to apologize at this time, because we, too, are offering to you a Scotchman. (Laughter.)

I am asking you if you will overlook that fact and consider only the past services that Frank MacDonald of the Clan MacDonald, has done in the Legislature as a member of this House for many years, on the Board of C.P.S., on the Council of C.M.A., the long years of service Frank has given as an alternate delegate to the A.M.A., and his present service as a delegate to the A.M.A. I place in nomination to succeed himself Frank MacDonald. (Applause.)

VICE-SPEAKER BAILEY: Are there any further nominations for this office?

Hearing none, the Chair declares the nominations closed.

Those in favor of electing Dr. MacDonald will say "aye."

... The motion was put to a vote and it was carried....

VICE-SPEAKER BAILEY: Dr. MacDonald is elected.

We go now to the Alternates of the American Medical Association.

Dr. Henry Gibbons III, of San Francisco, Alternate to Dr. Robertson Ward.

DR. FRANCIS ROCHEX (San Francisco): Mr. Speaker, members of the House: One of the fundamental requirements for the successful operation of a democratic organization is to have a long-term plan of sustained thought and action. This may best be accomplished by giving to potential office holders the opportunity to become acquainted with the responsibilities of their office before actually taking office.

The candidate whose name I wish to present to you has already served for one term. This candidate comes from a long line of medical men. These men have distinguished themselves in the service of organized medicine, first as pioneers in the San Francisco Medical Society, and also in the service of the California Medical Association.

This candidate has long shown himself to be an individual with a high sense of civic responsibility, a very hard worker who has served actively on many committees in the San Francisco Medical Society, and also in the California Medical Association.

He has been a member of the Board of Directors of the San Francisco Medical Society, has been a Delegate to this House for many years, is a member of the Board of Medical Examiners of the State of California.

I wish to place in nomination the name of Henry Gibbons to succeed himself.

VICE-SPEAKER BAILEY: Dr. Henry Gibbons has been nominated. (Applause.)

Are there any further nominations?

The Chair declares the nominations closed.

Those in favor of electing Dr. Gibbons will say "aye."

... The motion was put to a vote and it was carried....

VICE-SPEAKER BAILEY: Dr. Gibbons is declared elected.

Dr. A. E. Moore, San Diego, Alternate to Sam J. McClendon.

DR. DOUGLASS H. BATTEN (San Diego): Mr. Speaker, members of the House of Delegates: It is my pleasure to present to you the name of Dr. A. E. Moore, incumbent, to succeed himself as alternate to Dr. Sam J. McClendon.

VICE-SPEAKER BAILEY: Dr. A. E. Moore to succeed himself.

Are there any further nominations?

The Chair hearing none, declares the nominations closed.

Those in favor of electing Dr. Moore say "aye."

... The motion was put to a vote and it was carried....

VICE-SPEAKER BAILEY: Dr. Moore is elected. (Applause.)

Next incumbent is Dr. Frederic S. Ewens, Manhattan Beach, alternate to Eugene F. Hoffman.

DR. EWING L. TURNER (Los Angeles): Mr. Speaker, members of the House: It is my privilege as secretary of the Los Angeles County Association to place in nomination the name of a man who has long represented general practice in this area.

This doctor has been a delegate for two years to the Academy of General Practice and has been an important member of their hospital commission.

He has been for the past year a very active member of the Council of our Los Angeles County Medical Association, and his decisions are always just, and always honest, and upright.

It is a great pleasure for me to place in nomination the name of Dr. Frederic Ewens to succeed himself as alternate to Dr. Eugene Hoffman. (Applause.)

VICE-SPEAKER BAILEY: Dr. Frederic Ewens has been nominated.

Are there further nominations for this office?

The Chair hearing none, declares the nominations closed.

Those in favor of electing Dr. Ewens will say "aye."

... The motion was put to a vote and it was carried....

VICE-SPEAKER BAILEY: Dr. Ewens is elected.

Dr. Orris R. Myers, Eureka, alternate to John W. Green.

DR. LEON O. DESIMONE (Los Angeles): I may be out of order here in that I am from Los Angeles and Dr. Myers from Eureka.

However, I have known Dr. Myers for many years, and I wish to name him to succeed himself for this office.

Thank you.

VICE-SPEAKER BAILEY: Dr. Myers has been nominated to succeed himself.

Are there any further nominations for this office?

Hearing none, the nominations are closed.

Those in favor of electing Dr. Myers will signify by saying "aye."

... The motion was put to a vote and it was carried....

VICE-SPEAKER BAILEY: Dr. Myers is elected.

The next office is that of J. B. Price, of Santa Ana, alternate to L. A. Alesen.

DR. L. E. WILSON (Orange County): Mr. Speaker, members of the House: Dr. J. B. Price was elected a year ago to fill the unexpired term of the late Dr. John Ball.

I know personally during this past year he has been attending all the American Medical Association conventions, and the special convention in Washington.

At this time I would like to nominate him to succeed himself in that position as alternate to Dr. Lewis Alesen.

VICE-SPEAKER BAILEY: Dr. J. B. Price has been nominated.

Are there any further nominations?

Hearing none, the Chair declares the nominations closed.

Those in favor of electing Dr. J. B. Price will say "aye."

... The motion was put to a vote and it was carried....

VICE-SPEAKER BAILEY: Dr. J. B. Price is elected. (Applause.)

The last alternate, Dr. Henry A. Randel, from Fresno, alternate to Frank A. MacDonald.

Dr. Young.

DR. J. E. YOUNG (Fresno County): I do not know the background of Dr. Randel, but after seeing him night before last I was of the opinion he had some Scotch in him. (Laughter.)

We recognize Dr. Randel as a fine friend, a good doctor, and a person very conscious of the problems of organized medicine in relation to the public and private practitioner.

With that in mind, Mr. Chairman, I take great pleasure in nominating Dr. Henry Randel of Fresno as alternate to the American Medical Association. (Applause.)

VICE-SPEAKER BAILEY: Dr. Randel, of Fresno, has been nominated to succeed himself.

Are there further nominations?

Hearing none, the Chair declares the nominations closed.

Those in favor of electing Dr. Randel will say "aye."

... The motion was put to a vote and it was carried....

VICE-SPEAKER BAILEY: Dr. Randel, Scotch or Irish, is elected. (Applause.)

SPEAKER CHARNOCK: The next order of business is the election of C.P.S. Trustees.

C.P.S. Trustees, according to the By-Laws of C.P.S., are nominated by the Council, and are elected one at a time.

We will ask Dr. Daniels to give the Council nominations.

SECRETARY DANIELS: The Council nomination to fill the office formerly held by Donald Cass is Dr. Leon Desimone, of Los Angeles.

SPEAKER CHARNOCK: Dr. Leon Desimone, of Los Angeles, has been nominated for C.P.S. Trustee for this office.

Is there any other nomination?

The Chair hearing none, declares the nominations closed.

Will you vote by acclamation?

... There were calls of "yes." ...

SPEAKER CHARNOCK: Those in favor of Dr. Desimone will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: He is elected. (Applause.)

Dr. Daniels, will you give the nomination from the Council for the office held by Dr. Kendrick A. Smith, who cannot succeed himself?

SECRETARY DANIELS: The Council nominated Dr. Merlin Newkirk of Los Angeles.

SPEAKER CHARNOCK: Dr. Merlin Newkirk has been nominated for this office.

Are there any further nominations?

The Chair hearing none, declares the nominations closed.

Those in favor of Dr. Newkirk will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: He is declared elected. (Applause.)

Now, Dr. Daniels will give us the nomination for the next office.

SECRETARY DANIELS: The Council nominated Dr. Francis Hodges to succeed himself.

SPEAKER CHARNOCK: Dr. Francis T. Hodges has been nominated by the Council to succeed himself as Trustee. Are there any other nominations?

The Chair hearing none, declares the nominations closed.

Those in favor of Dr. Hodges will signify by saying "aye."

... The motion was put to a vote and it was carried. ...

SPEAKER CHARNOCK: Dr. Hodges is elected. (Applause.)

The next nomination, Dr. Daniels.

SECRETARY DANIELS: The Council nominated Mr. Robert A. Hornby to succeed himself.

SPEAKER CHARNOCK: The Council has nominated Mr. Robert A. Hornby to succeed himself.

Are there any nominations from the floor?

The Chair hearing none, declares the nominations for this office closed.

Those in favor of Mr. Hornby will signify by saying "aye."

... The motion was put to a vote and it was carried. ...

SPEAKER CHARNOCK: Mr. Robert A. Hornby is elected to the Board of Trustees. (Applause.)

This is the last office in this group to which there is a vacancy.

Dr. Daniels!

SECRETARY DANIELS: The Council nominated Dr. Ed Bruck, of San Francisco, to fill this vacancy.

SPEAKER CHARNOCK: Dr. Edward Bruck has been nominated for this office.

Are there any other nominations?

The Chair hearing none, declares the nominations closed.

Those in favor of Dr. Bruck will signify by saying "aye."

... The motion was put to a vote and it was carried. ...

SPEAKER CHARNOCK: Dr. Bruck is elected. (Applause.)

The next order of business is the election of two members to the C.M.A.-C.P.S. Liaison Committee.

Now, Reference Committee No. 4 has some words about that Liaison Committee, and we will hold up that order of business with your permission until we have heard from Reference Committee No. 4.

(Discussion between Speaker Charnock and Executive Secretary John Hunton.)

SPEAKER CHARNOCK: All right, it will be Reference Committee No. 1 that is going to talk about C.P.S.-C.M.A. Committee.

Announcement by the Secretary on the nominations of members of Standing Committees.

Dr. Daniels!

REPORT OF THE COMMITTEE ON COMMITTEES

DR. DANIELS:

Committee on Associated Societies and Technical Groups:

Hartzell H. Ray	San Mateo	1954
James F. Regan	Los Angeles	1955
Gordon MacLean, chairman	Oakland	1956

Committee on History and Obituaries:

J. Marion Read, chairman	San Francisco	1954
John F. Barrow	Los Angeles	1955
J. Roy Jones	Sacramento	1956
George H. Kress	Ex-officio	
Editor and Secretary	Ex-officio	

Committee on Hospitals, Dispensaries and Clinics:

Jay S. Crane, chairman	Los Angeles	1954
Howard C. Miles	Salinas	1955
Karl Schaupp, Jr.	San Francisco	1956

Committee on Industrial Practice:

E. Vincent Askey	Los Angeles	1954
Packard Thurber, Sr., chairman	Los Angeles	1955
Harold Downing	Fresno	1956

We have made this nomination, though we expect this committee will probably be eliminated by the adoption of one of the resolutions. So, we have just renominated the former committee, and they may not have the privilege of serving.

Committee on Medical Defense:

Alfred B. Wilcox	Santa Barbara	1954
H. Clifford Loos, chairman	Los Angeles	1955
Leslie B. Magoon	San Jose	1956

Committee on Medical Economics:

L. H. Fraser, chairman	Richmond	1954
Roy Ouer	San Diego	1955
Robert Patrick	Taft	1956

Committee on Medical Education and Medical Institutions:

M. Laurence Montgomery	San Francisco	1954
Walter E. MacPherson, chairman	Los Angeles	1955
Paul Foster	Los Angeles	1956

Committee on Military Affairs and Civil Defense:

Justin J. Stein, chairman	Los Angeles	1954
Frank F. Schade	Los Angeles	1956
William L. Bender	San Francisco	1956
John C. Ruddock, consultant	Los Angeles	

Committee on Postgraduate Activities:

Lester S. Gale	Bakersfield	1954
Herbert W. Jenkins	Sacramento	1955
Edward C. Rosenow, chairman	Pasadena	1956

Committee on Public Policy and Legislation:

Dan Kilroy	Sacramento	1954
James C. Doyle	Beverly Hills	1955
Dwight H. Murray, chairman	Napa	1956
President and President-Elect	Ex-officio	

Committee on Scientific Work:

Howard F. West	Los Angeles	1954
George H. Houck	Palo Alto	1955
Robert L. Dennis	San Jose	1956
Secretary (chairman)	Ex-officio	
Secretaries, Sections on General Medicine and General Surgery		1954

Committee on Public Relations:

Dwight H. Murray, Chairman, Committee Public Policy and Legislation (ex-officio)
L. H. Fraser, Chairman, Committee on Medical Economics (ex-officio)
H. Gordon MacLean, Chairman, Committee on Associated Societies and Technical Groups (ex-officio)
President (ex-officio)
President-Elect (ex-officio)
Secretary (ex-officio)
J. Lafe Ludwig, Los Angeles
Frank A. MacDonald, Sacramento

Physicians' Benevolence Committee:

Axcel E. Anderson, chairman	Fresno	1954
Elizabeth Mason Hohl	Los Angeles	1955
Ford Cody	Los Angeles	1956

SPEAKER CHARNOCK: You have heard the report by the Secretary on the Council's nominations of members of Standing Committees. That requires the approval of the House. May we have a motion to that effect.

... It was moved and seconded that the report be approved....

SPEAKER CHARNOCK: It has been moved and seconded that the House of Delegates approve these nominations of the members of the Standing Committees.

Those who are in favor of approving these will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: They are appointed.

We will now have the report of Reference Committee No. 1, J. W. Moore of Ventura, chairman.

REPORT OF REFERENCE COMMITTEE No. 1

DR. MOORE: Mr. Speaker, and members of the House of Delegates: The duty of Reference Committee No. 1 is to review and to report upon the reports of the officers, the Councilors and Standing and Special Committees of this organization. For the sake of clarity and I hope brevity, we have divided our report into sections. I would first like to thank the members of the Reference Committee, Dr. Ralph Teall, Sacramento, and Dr. James Graeser, Oakland, for their assistance in the preparing the report.

Section 1. The committee has carefully reviewed the reports of the General Officers as printed in the Annual Reports Bulletin with the exception of the reports of the Secretary, Treasurer, and Executive Secretary which are being reviewed by Reference Committee No. 2. The committee wishes highly to commend the President, Dr. Lewis A. Alesen, and the President-Elect, Dr. John W. Green, for the excellent work they have done for the California Medical Association in the past year.

Dr. Alesen has received editorial comment all over this country for his clear and positive stand upon various social and political problems as well as the problems of medicine. The committee feels that Dr. Alesen has done yeoman service for the California Medical Association and we are sure that every member of the Association owes him a debt of gratitude.

Mr. Speaker, I move the adoption of this section of our report.

SPEAKER CHARNOCK: Is there a second?

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that we adopt this section of the report.

Is there any question?

... The motion was put to a vote and it was carried....

DR. MOORE: Both Dr. Alesen and Dr. Green have continued the practice of yearly visits to all of the component medical societies. The committee feels that they are very valuable indeed and should be continued. The committee recommends the approval of the reports of the General Officers.

Mr. Speaker, I move the adoption of this section of the report.

SPEAKER CHARNOCK: Is there a second?

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that we approve this section of the report.

Is there any question?

Those in favor will signify by saying "aye."

... The motion was put to a vote and it was carried....

DR. MOORE: Your committee has reviewed the report of the Council and recommends its approval. The committee hopes that each delegate has read the report of the Council since it is a brief review of the year's activities. This committee wishes to congratulate the Council on the work accomplished and to commend them for their untiring work in behalf of the California Medical Association.

Mr. Speaker, I move the adoption of this section of our report.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that we accept this section of the report. Is there any question?

All those in favor will say "aye."

... The motion was put to a vote and it was carried....

DR. MOORE: Your committee has reviewed the report of the chairman of the Council, the report of the president of the Trustees of the California Medical Association, the report of the Executive Committee, and the reports of the Speaker and Vice-Speaker of the House of Delegates. The committee recommends the approval of all of these reports and again wishes highly to commend the officers of the Association who held these positions and made the reports.

It is noted that funds of the Trustees of the California Medical Association, in an amount exceeding one million dollars, are presently held entirely in low-interest Government obligations. It is suggested that investigation be made as to the possibility of investing these funds in equities providing a higher yield and not subject to the shrinking effects of further inflation. It is suggested that the Council in its capacity as the Trustees of the California Medical Association should consider this problem and if necessary make whatever changes in the by-laws of the corporation to accomplish this end are needed.

Mr. Speaker, I move the adoption of this section of our report.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that we accept this section of the report. Is there any question?

Those in favor will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is accepted.

DR. MOORE: The report of Dr. Dwight L. Wilbur, Editor of CALIFORNIA MEDICINE, and the report of the Editorial Board of CALIFORNIA MEDICINE, Dr. Dwight L. Wilbur, chairman, have been reviewed. This committee recommends the approval of both reports and again would like to call the attention of the House to the fact that CALIFORNIA MEDICINE is one of the outstanding medical publications in the land. We commend Dr. Wilbur and the members of the Editorial Board for their fine work.

Mr. Speaker, I move the adoption of this section of our report.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded we accept this section of the report. Is there any question?

Those in favor will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is accepted.

DR. MOORE: The committee has reviewed the reports of the various District Councilors and of the Councilors-at-Large. The committee recommends approval of all these reports. The committee hopes that every member of the House of Delegates and every member of the California Medical Association is aware of the amount of time these men must spend in working on the Council and the great effort and energy involved in fulfilling their duties.

Mr. Speaker, I move the adoption of this section of our report.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that this section of the report be accepted. Is there any question?

Those in favor will signify by saying "aye."

... The motion was put to a vote and it was carried....

DR. MOORE: We have reviewed the report of the Legal Counsel and recommend its approval. It seems obvious to the committee from reviewing this report that our Legal Counsel must spend a great deal of time upon California Medical Association business. We commend Mr. Hassard for work well done.

Your committee has reviewed the reports of the following Standing and Special Committees: The Committee on Associated Societies and Technical Groups, the Auditing Committee, the Committee on History and Obituaries, the Committee on Hospitals, Dispensaries and Clinics, the Committee on Medical Defense, the Committee on Medical Economics, the Committee on Medical Education and Medical Institutions, the Committee on Scientific Work, the Advisory Planning Committee, and the Committee on Rural Medical Service. Your committee recommends approval of these reports. Mr. Speaker, I move the adoption of this section of our report.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that we accept this section of the report. Is there any question?

Those in favor will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is accepted.

DR. MOORE: The committee has reviewed the report of the Physicians' Benevolence Committee and the Committee on Postgraduate Activities. We recommend approval of both of these reports. There is a suggestion in the report of the Physicians' Benevolence Committee that the contribution of the California Medical Association to the Benevolence Fund should be increased to more than $1.00 per member per year. Your committee recommends that this suggestion be referred to the Council for such action as it may deem advisable.

In the report of the Committee on Postgraduate Activities, the House of Delegates is requested to direct the Council to continue the allocation of funds for the support of that committee, thereby making possible postgraduate opportunities for its members. Reference Committee No. 1 is strongly in favor of this and so recommends.

Mr. Speaker, I move the adoption of this section of our report.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that we accept this section of the report. Is there any question?

Those in favor will signify by saying "aye."

... The motion was put to a vote and it was carried....

DR. MOORE: The committee has reviewed the report of the Committee on Military Affairs and Civil Defense. The committee feels that the members of this committee have done excellent work. The committee was interested in the activity of the Northern California Advisory Committee in assisting relocation of returning medical and dental and veterinarian reserve officers to civilian practice after completion of their period of active duty in the military service. We feel that this is highly commendable and recommend that a similar activity be set up by the Southern California Advisory Committee. The committee recommends the approval of this report.

Mr. Speaker, I move the adoption of this section of our report.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that this section of the report be accepted. Is there any question?

Those in favor will signify by saying "aye."

... The motion was put to a vote and it was carried...

SPEAKER CHARNOCK: It is accepted.

DR. MOORE: The committee listened with interest to the oral report of Dr. Dwight Murray, chairman of the Committee on Public Policy and Legislation. The committee recommends approval of the report and wishes to commend Dr. Murray, Dr. Kilroy and Mr. Ben Read for their excellent work on behalf of the medical profession in the State Legislature.

The committee has reviewed the report of the Committee on Public Relations and has listened with interest to the oral report made on the floor of the House. We recommend the approval of these reports and wish to highly commend Mr. Clancy and his assistants, Mr. Gillette and Mr. Pettis, for their fine work in the public relations field for the California Medical Association.

Mr. Speaker, I move the adoption of this section of our report.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that we accept this section of the report. Is there any question?

Those in favor please signify by saying "aye."

... The motion was put to a vote and it was carried....

DR. MOORE: The report of the Cancer Commission was carefully reviewed and the committee wishes to commend Dr. Ian Macdonald and the members of the commission for their excellent work in this field. The committee feels that their work in investigating the various so-called cancer cures as they arise is extremely important and should certainly be continued. The committee recommends the approval of this report.

Mr. Speaker, I move the adoption of this section of our report.

DR. ARTHUR A. KIRCHNER (Los Angeles): I second the motion.

SPEAKER CHARNOCK: It has been moved and seconded that we accept this section of the report. Is there any question?

Those in favor will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is accepted.

DR. MOORE: The report of the C.M.A. Blood Bank Commission has been reviewed and the committee recommends its approval. The committee feels that the California Medical Association can point with pride to the California Blood Bank system and the committee feels that Dr. John Upton and the Blood Bank Commission can take great credit for this fine accomplishment.

The report of the Committee on Industrial Health with its supplemental report has been carefully reviewed. This committee recommends that the proposals in the supplemental report be referred to the Council for appropriate action without specific action on the part of the House of Delegates.

Mr. Speaker, I move the adoption of this section of our report.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that we accept this section of the report. Is there any question?

Those in favor will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is accepted.

DR. MOORE: The report of the C.M.A.-C.P.S. Liaison Committee has been reviewed. The committee notes that it has been recommended by the chairman, Dr. L. A. Alesen, that the C.M.A.-C.P.S. Liaison Committee be dissolved. In view of the recommendations of the C.P.S. Study Committee that have been adopted in the past by the House of Delegates your Reference Committee believes that this recommendation should be followed. We therefore recommend the approval of this report.

Mr. Speaker, I move the adoption of this section of our report.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that we accept this section of the report. Is there any question?

Those in favor will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is accepted.

DR. MOORE: The reports of the C.P.S. Study Committee and the C.P.S. Fee Schedule Committee were reviewed. The work of the C.P.S. Study Committee has been completed and previously reported upon. The activities of the C.P.S. Fee Schedule Committee have been largely integrated with the Medical Services Commission. Our committee recommends the approval of both of these committee reports.

The committee has reviewed the report of the Medical Services Commission including the supplemental report and recommends approval.

Mr. Speaker, I move the adoption of this section of our report.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that we accept this section of the report. Is there any question?

Those in favor will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is accepted.

DR. MOORE: Mr. Speaker, I move the adoption of our reports as a whole.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that we accept this report as a whole.

Those who are in favor will signify by saying "aye."

. . . The motion was put to a vote and it was carried. . .

SPEAKER CHARNOCK: The report as a whole has been accepted from Reference Committee No. 1.

We wish to thank Dr. Moore, Dr. Graeser, and Dr. Ralph Teall for their work on this committee. (Applause.)

The C.M.A.-C.P.S. Liaison Committee has been discontinued by your recent action. There will be no action on Item No. 7.

C.P.S. PLAQUE FOR DR. CASS

At this time, the officers from C.P.S. have a little job they want to do, and I will ask them to come forward at this time.

Will the members of the Board of Trustees come forward, including the new members who have just been elected.

DR. JOHN W. RUMSEY (San Diego): This is not, as has been suggested, "The Last Supper." (Laughter.)

But, it is the end of the line in this particular job for a man who has contributed very much to C.P.S.

The doctors of California owe Don Cass a great debt. He has worked hard. His bald pate has taken many brickbats. A good many of them have bounced off; a good many of them have sunk in.

He has stood it well. He is a very vigorous individual, or he wouldn't have been able to.

I want to present to Don Cass, for the Board of Trustees, California Physicians' Service, and I feel I represent California medicine doing this as Past President, a plaque for the service he has done for C.P.S. and for California medicine.

Don! (Standing applause.)

DR. DONALD CASS: The last time I got one of these plaques was several years ago when I retired as President of the C.M.A. I couldn't talk. I am not doing so good now. (Laughter.)

Fellows, I haven't done anything special to deserve such a thought as this, but I will tell you one thing, as long as I live I will treasure it. (Applause.)

. . . Announcements. . .

VICE-SPEAKER BAILEY: We will now go to the report of Reference Committee No. 2, Dr. Robertson Ward, chairman; Dr. John E. Vaughan, Dr. Thomas P. Hill.

Dr. Ward!

REPORT OF REFERENCE COMMITTEE No. 2

DR. WARD: Mr. Speaker, and members of the House of Delegates: Your committee, composed of John E. Vaughan, Thomas P. Hill and Robertson Ward, chairman, has studied the report of the Secretary and wishes to emphasize that the membership read the proceedings of the Council in order to be kept informed upon important decisions reached by that august body.

That was recommended in the Secretary's speech, and we would like to emphasize that part of it.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

VICE-SPEAKER BAILEY: It has been moved and seconded that this section of the report be adopted. Those in favor will say "aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER BAILEY: It is accepted.

DR. WARD: In the report of the Executive Secretary, it was thought worth while to emphasize the position of leadership in which California finds herself. This is brought out by the fact that California holds second place only to New York in the number of delegates to the American Medical Association. We feel that California holds second place to none in influence and guidance of national policies. There is a reason for this and that reason is to be found in our tendency to anticipate conditions before they actually come into being. It is gratifying to note that our Executive Secretary is in a position to offer leadership as part of the advisory committee of the American Medical Association's Public Relations Department.

We feel that our final recommendation today will give evidence of California's forward looking attitude for the good of American medicine. Your committee respectfully suggests the perusal of the Executive Secretary's report by all members of the profession in California.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

VICE-SPEAKER BAILEY: It has been moved and seconded.

All those in favor will say "aye."

. . . The motion was put to a vote and it was carried. . . .

DR. WARD: Your committee has studied the Treasurer's Report and the Budget. We were pleased to note that the Council of the California Medical Association is concerned about and anxious to reduce dues of our members. However, in view of the impending activities in relation to a basic science law and the expenses of the Association relating thereto, your committee recommends a reversal of the stand taken by the Council and favors maintenance of the regular dues at $40.00 per year.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

VICE-SPEAKER BAILEY: It has been moved and seconded. Is there any discussion?

Those in favor will say "aye."

. . . The motion was put to a vote and it was carried. . . .

DR. WARD: I know that it is unusual to have a reference committee come out and vote for a con-

tinuation of dues, or not vote for a reduction of dues, but I think there is plenty of evidence to show that that may be money that we will need.

The final matter referred to your reference committee was the resolution by J. Lafe Ludwig calling for an increase in the California Medical Association dues of $25.00 per year to be turned over to the American Medical Education Foundation.

In keeping with California's traditional anticipation of coming events, your committee offers the following substitute resolution in hopes that it will set the pattern which can and will be followed by other states to provide medical education independent of Government subsidies. The resolution is:

WHEREAS, The need for funds for the maintenance of our medical schools is obvious; and

WHEREAS, These funds must be supplied by medicine rather than through government subsidies; therefore be it

Resolved, That the dues of the California Medical Association be raised $25.00 per year for active members; and be it further

Resolved, That the dues thus collected be forwarded to the American Medical Education Foundation for distribution among those medical schools which do not receive the major portion of their support from tax sources.

Now, before moving the adoption of this section of the report, I want to point out to you that in the previous section of the report we have called for dues remaining at $40.00, and that has been passed by you.

Now, in adopting this section of the report, you are making the dues $65.00 a year, and the funds will go as were directed in this motion.

Mr. Speaker, I move the adoption of this section of the report.

... The motion was seconded....

VICE-SPEAKER BAILEY: It has been moved and seconded. Is there any discussion?

DR. JOHN W. GREEN (President-Elect, Vallejo): Mr. Speaker, members of the House: As you know, of course, this is a very important thing. There are two sides to this debate. My side is the affirmative side, because by the action of your Council, I was made the chairman of this committee for the State of California.

I have given it a great deal of time. I have been to Chicago on two separate occasions to hear the reports that come from all over the United States on this subject.

The last time I was there in January, we spent an entire day receiving reports from the forty-eight states, and the American Medical Association Woman's Auxiliary.

At this meeting, Dr. Anderson, who is the chairman for the American Medical Education Foundation fund, had this to say, and I would like to read it to you. Although it takes a little time to read, I think it is necessary for me to do so:

"Dr. Donald G. Anderson gave a brief summary of the history of the Foundation and the National Fund for Medical Education. He then read a letter from President Eisenhower to Mr. Sloan Colt, president of the National Fund for Medical Education, in which Mr. Eisenhower stated:

"1. He hoped those selected to lead the campaign to alleviate the financial stress in our medical schools would cooperate willingly despite their other interests;

"2. Private support of higher education in America is fundamental to the democratic tradition;

"3. The nation's 79 medical schools are the keystones of national health, the prime factors in our ability to maintain production levels and man our armed forces and they must not be prevented from meeting their responsibilities because of financial stress; and

"4. Medical education can best be financed through a central fund.

"In the letter, Mr. Eisenhower stated that it was impossible to exaggerate the vital importance of the fund to our national welfare and he assured Mr. Colt of his wholehearted support."

Now, Mr. Colt happens to be the chairman of the National Foundation for Education, of which medical education is a fraction. We are dealing principally within our House with the fraction.

The Woman's Auxiliary report was given by Mrs. Frank Gastineau, chairman.

It was as follows:

She advised that the Auxiliary also publish a pamphlet entitled, "Your Help is Needed by the A.M.E.F.—Every Auxiliary a Contributor." She further reported that the Auxiliaries had contributed $16,064 to the Foundation since last June and that all Auxiliaries had been asked to send in their contributions before June 1."

Further in the proceedings in the morning, Dr. Herman Weiskotten, chairman of the Council on Medical Education and Hospitals of the American Medical Association and a member of the A.M.E.F. board of directors, addressed the state chairmen and asked them to do everything possible to counteract the claims that medical education has become unjustifiably expensive. He reported that the greatly increased cost of the conduct of medical schools today is justified by the vast changes in medical education in recent years.

Dr. Weiskotten advised that in order to meet the responsibility brought by the advances and changes in medical education, it has been necessary for schools to provide satisfactory laboratories, equipment and personnel for the basic medical sciences as well as adequate hospital and outpatient facilities, with competent teachers to guide and supervise students in their clinical training.

Medical education in the United States has become individualized, he added, and it has laid a foundation for greatly improved types of medical care for the American public.

Dr. Weiskotten also mentioned that practically all of the research programs of the medical schools

have been supported by outside grants and are not included in the operating budgets of the schools. He further stated that it is the instructional budgets which are to be balanced through the efforts of the National Fund and the Foundation.

Now, somebody has said, "Well, how long is this program subsidy by us going to continue?" That is a pertinent question to ask. We realize that it has to go along, perhaps as long as we graduate medical students.

In view of the national need in this respect, I want to say how they feel about it on Capitol Hill in Washington.

Senate Bill 1748 to grant the National Fund for Medical Education a national charter was introduced in the Senate last week by Senator Robert A. Taft of Ohio. Through the proposed legislation, the National Fund would be on the same footing as the American Red Cross and a handful of other agencies who enjoy the prestige of a congressional charter. Also it would help immeasurably in the fund's approach to industry and business for support of their program to help the nation's medical schools maintain financial independence and regain solvency.

So, you see, there are many people thinking about this problem besides us.

I don't have to say to this House of Delegates that every man here knows he owes something to his medical school. That is a self-evident thing. But the question is, how many would give it voluntarily? In last year's report, California stood at the foot of the list with a little over $9,000, with a membership of 11,000 men and women.

As your representative in Chicago, I felt very small in that meeting because a state like Nebraska raised $48,000. Think of it! Small states like South Dakota, Nevada, little areas, did practically as well as we did.

In my remarks to the Council the other morning, I tried to put this whole matter on the basis of need, and voluntary subscriptions to take care of this need. There are men who feel that the voluntary method of doing it is the proper way of doing it. But, I can assure you that that has not been the answer to the problem, much as it might be.

I didn't state before that committee and the Council one other thing. I tried to keep this matter out of the debate, but I must say here and now something that I should have said at that time. Perhaps it is better to say it here: that when bills for subsidization of the medical schools have been presented before Congress and heard in committees, principally the Committee on Labor and Education, we have always had on that committee one of medicine's greatest adversaries, Senator Murray from Montana. He attacks us from every source possible. He has always been for compulsory health insurance and bureaucratic and political medicine. He still is.

He made this remark in his testimony, that to his certain knowledge in 1951 only 1.3 per cent of the doctors in this country had given voluntarily to this fund.

Now, in the National Foundation, ladies and gentlemen, of which I say we are a part, they have men collecting funds from industry, from pharmaceutical houses, other groups, for instance the Auxiliary, and last but not least, somebody to reckon with nevertheless, they get certain funds from labor organizations, and they have representation in the committee of the National Fund.

They know exactly year by year to the cent how much we contribute as doctors to this.

Now, it would be a sad commentary if when that bill is here again, which it will be this year, that Senator Murray could point to the great state of California and say that we were not in favor of this thing as evidenced by a defeat of a resolution of this character.

Now, I should like to have Mr. Murray know that we still feel that we owe something to medicine. The Auxiliary members seem to appreciate it much more than we do, because they are quite active in that.

So, gentlemen, I should make this one other remark; it has been brought up before that the private schools didn't participate in this thing as much as they should. In other words, tax-supported schools were getting just as much of the 1/79 cut of it as private schools. We know that. That has been considered. That policy has been changed. You can earmark your money for any private school you wish, and every cent of that earmarked money will go to your school, besides a proportional cut of the balance of the fund.

Further than that, I was just reminded here by some statistics a minute ago, that I was entirely in error in saying what proportion of the entire fund came from that National Foundation, and I find out by the latest report that they are participating almost dollar for dollar instead of on a basis of 1 to 4.

So, fellows, get behind this resolution. Pass it, I urge upon you. (Applause.)

VICE-SPEAKER BAILEY: Dr. Wayne Pollock.

DR. WAYNE E. POLLOCK (Councilor, Eleventh District): I wish to speak in opposition to this resolution. First I want to make it clear that I thoroughly approve of contributing to medical school funds by physicians and the public in general. I, personally, do contribute. I have had some small part in assisting to raise funds for one of our private medical schools in Northern California, and I am happy to say that that institution alone raised from its alumni last year about ten times the sum which Dr. Green has mentioned as being given by California doctors to the Medical Education Foundation Fund.

Now, I think it would be a mistake to do this in this way, because I think the principle is wrong. You will recall that some three years ago C.M.A. gave $100,000 of its funds to the Medical Education Foundation Fund.

Of that sum, and from the fund that year, ap-

proximately $15,000 was distributed to each medical school in the country, including our tax-supported schools. In other words, less than the amount which we alone gave returned to our schools, less than half of it returned to the three schools which needed it.

Now, our tax-supported schools have no problem in finances. They may not have everything they want, but they have essentially everything they need. And if you give them many times the amount of money that we are talking about today, the Legislature would simply deduct that from the budget and continue to give them what they need.

The prime need is our private schools, our privately-endowed institutions, and some of them are really in distress.

It is proposed here that by levying $25.00 additional dues on our membership, we would raise almost $300,000, which we would then put in this fund. Obviously, only a fraction of this would ever return to California.

I am just provincial enough to think that charity begins at home, and I wonder if maybe we shouldn't, before we start worrying about all these schools in the country, worry about our own here, whose problems should be a little more, perhaps, paramount to us than state universities throughout the country; and even some of the other endowed medical schools are more fortunate than some we have here.

It has been stated that we can now fix this up and earmark it. After the first outcry among doctors as to the distribution of this—and believe me as I went around through the twenty counties I am supposed to represent, I was in effect reprimanded on several occasion by a number of doctors who had two complaints. First, they felt it was morally wrong for the Council of C.M.A. to have distributed that amount of our assets in that fashion, and the philanthropies were properly the right of the doctor involved.

Secondly, they objected to having it evenly distributed among tax-supported and non-tax-supported schools.

The following year, in order to allay criticisms of the latter, it was announced that you might earmark your donation for the school of your choice, and that was done, but the distribution was the same. If Dr. Zilch earmarked his $100 to his university, the university received exactly the same thing, and it was the old Community Chest distribution idea. If you didn't like one agency, and you wanted to give it all to another, they still ended up with the same total sum of money.

I understand that has now been changed, and earmarked money is received in addition to the money which is evenly distributed.

You might be interested to know the second year there were two state universities that refused to accept this. I understand one was the University of Oklahoma, and they returned their second grant and said, "We haven't spent our first grant." When they returned it, they said, "Give it to somebody who needs it."

Now, obviously, that is what we should do. We should give it to those who need it.

I think it would be wrong to make this a matter of dues, because of the principle involved.

For many years, we have had that slogan, "The voluntary way is the American way." We have refused to give our wholehearted endorsement to medical plans that do not offer their participants free choice of physician, the right to change their doctor if they don't like him, free choice of hospital.

We are all proud of the activities of our president in going up and down the country, extolling the virtues of free enterprise and freedom to make that possible.

We put on a program last night entitled, "Blueprint for Freedom." What kind of hypocrites would we be if we here today decide how much a man gives, and what he gives it for?

If we embark on this principle, what is to keep some enthusiast from coming up next year and saying, "The Polio Fund, or Diabetes Fund, or epileptics need money, and we think you should give so much," or even the Community Chest?

I urge you to let every man give to whom he wants the amount he wants to give, and I can assure you there are many more thousands of dollars being given in California by doctors than would be indicated by Senator Murray, and Dr. Green's analysis, which you have just heard.

I hope you defeat this resolution. (Applause.)

VICE-SPEAKER BAILEY: Dr. Ed Reynolds!

DR. ED REYNOLDS: I have been impressed by Dr. Green's eloquent defense or support of the idea that we contribute by assessment to medical schools.

Certainly, it has long been traditional among medical men to train our successors. It was done by Hippocrates. It was done by doctors a hundred years ago, who took apprentices into their offices and trained them.

Today, perhaps it is entirely fitting that since we can no longer take our apprentices into our offices, that we contribute in an organized manner to the support of medical schools.

We contribute in an organized manner to a great many activities and charities which were formerly a matter for the individual or the family.

Like Dr. Pollock, I see one or two difficulties. Perhaps certain inequities might arise in any endorsed program. In the first place many of us contribute a great amount of time. Some men give thousands of dollars of their time every year for the training of medical schools. To ask them to contribute additional money is hardly fair.

Others have no opportunity to participate in medical education. Some physicians contribute heavily to their very own medical schools, particularly when they are graduates of schools which are privately endowed.

One school in this state, supported by a religious body, receives little help outside of its own denominational members and its own graduates.

I think the idea is beautiful; perhaps it is a wonderful one. I am just wondering whether we have a moral right to levy this tax for gift purposes on our membership.

I wouldn't oppose it personally, but I wonder whether we shouldn't either submit such a thing as this to a referendum or vote of the membership, or, at least, ask that the councils of a majority of the counties approve this before it is adopted by us. (Applause.)

VICE-SPEAKER BAILEY: Dr. Teall!

DR. RALPH TEALL (Sacramento): Mr. Speaker and members of the House: I have been a Councilor for an hour and twenty-seven minutes, and am about to prove my unfitness for the position. (Laughter.)

I can only grant 100 per cent support of practically everything that has been said by Dr. Green.

However, last night I was thrilled as most of you were by the eloquent defense by Clarence Manion of the principles of freedom which made of the United States the greatest country the world has ever known, and has brought each individual citizen of the United States to the greatest era of self-responsibility.

I am impressed in the light of his comments with the fact that government is being asked to do a great many things which should be the function of the individual, and that with each request we make of the government to assume individual responsibilities, we move closer to the ideal of the socialists.

It is my humble concept that this applies not alone to Federal government, state government, local government, but also to the government of such organizations as our own. It has been held by courts that there is an inherent property right in membership in your county medical society, and I assume that there is also an inherent property right in membership in the California Medical Association.

If a man does not pay dues, he forfeits this property right. In effect, then, we are demanding that unless a man contributes whatever amount we say, $25.00 or any amount in the form of dues, he forfeits the property right which is inherent in his membership in the California Medical Association.

I wonder if we want to go that far. It seems to me that all of us are intensely interested in the future of medical schools and in their financial support.

I am quite certain that the voluntary method of soliciting these funds, at least among California doctors, has not been exhausted.

I am quite certain in my own mind that many of us are totally unwilling to assume the coercive power, the police power of government, of our own government, our own Council, or this House of Delegates, to force contributions which should be voluntary contributions.

I would, therefore, move, Mr. Speaker, that this resolution be amended to defer action until the next meeting of the House of Delegates, following a referendum of county medical society boards of directors to ascertain the position of the members of the California Medical Association. (Applause.)

VICE-SPEAKER BAILEY: Thank you, Dr. Teall.

Is there a second to the motion to amend?

... The motion was seconded....

VICE-SPEAKER BAILEY: Discussion on the motion to amend is before the House. The motion to amend is to the effect this be referred to the board of directors of the county medical associations.

A MEMBER: Mr. Speaker, may we discuss the original motion?

VICE-SPEAKER BAILEY: As soon as the motion to amend is disposed of.

Dr. Askey, do you wish to discuss the motion to amend?

DR. E. VINCENT ASKEY: I do, sir.

In discussing the motion to amend, I have to discuss the original motion also, sir, but I direct it to the amendment. (Laughter.) I will try to follow the rules of order, sir.

The discussion has come up that we should send our money to California institutions. Many of us in this state, in fact, perhaps the majority, are men who have come to California from other schools of the United States, some of which are very small institutions, which have delivered to California some of our best physicians.

If we as loyal Californians—and I am one—direct that it go only to the California institutions, it takes away from the possible good for the benefit of medicine as a whole.

As I look at this amendment, it refers to the membership of our Association of a proposed referendum and to our Council. It seems to me that the original resolution came from the Council of the California Medical Association. In discussing this action, they have already, as it was called to our attention, given $100,000 as funds of our Association to this fund.

I might tell you that that gave to American medicine and this fund a great lift, and it directed to many other associations of the United States, attention to it that otherwise could not have come.

The decision to do that was purely and simply that of the Council of this Association.

Now, these proposed dues will be dues, and there is a move to indicate that California is leading and believes that this is the right thing to do.

Other state associations have already added to their dues for this purpose, notably Illinois, Tennessee, and others. So, unfortunately from our standpoint, this is not the primary action this way. I wish it were.

Now, many of us have had in the past good intentions. Personally I have given to my medical school and I felt that the rest of it was being taken care of in a good way by the $100,000 of my Association.

Many of you gentlemen here today have had just as good intentions as I have had, but somebody has said that the roads to hell are paved with good intentions that were never carried out.

Now, those that agree that this is a good thing would like to see this put in an organized way so that that which we can afford to do will be placed at the right level.

I would agree with a lot of the discussion of Dr. Teall and the rest of them and Dr. Wayne Pollock, that some better method should be worked out. I stand second to none of you in believing that we should have it voluntary and should do it as individuals. I would suggest that if you wish to do that, that we would look at it like this: that if these dues are placed on, and I hope they are, that those of you who feel that you don't like it that way would just in your mind feel, "Well, my dues are going for the ordinary upkeep of the Association, and the remainder of those dues from the other fellows are going to the other part." It is merely a matter of bookkeeping, gentlemen. (Laughter.)

I would suggest this, that this not be a direction that these funds absolutely must go to that, but raise your dues so that if the Council of the California Medical Association shall see fit that certain of your funds which are designated should go one way or the other, that you leave the decision of what these funds shall be used for to the discretion of the Council.

That way, it is true your dues will be raised to $65.00, but you have a group of Councilors that can be trusted to put it to the best place for American medicine.

I am talking to the amendment now. If you want amendments, I think that you should amend it that these additional funds be raised by the dues, and the Council be instructed to put it to the best use for the development and sustaining of American freedom in medicine which, I think, is very important.

I ask that you defeat this amendment, and if you desire, I will introduce another amendment after this is proposed, that the dues be raised to $65.00, and that the Council be instructed to use the dues of the California Medical Association for their appropriate service, knowing that these other funds are legitimate and very fine things to be discussed and acted upon, I think that we must and should in some way take the lead.

Now, Dr. Green made one statement and I hope it is true, that the distribution of these funds to the state tax-supported institutions has been taken care of.

If I read the original resolution which was presented here, I understand this was to go to non-tax-supported schools, and if that is true I think it will clarify the situation.

I hope that you defeat this amendment on that basis, and I hope that the original motion will be sustained. Thank you.

VICE-SPEAKER BAILEY: At this time you can speak to the amendment in the same general way that Dr. Askey did. (Laughter.) Dr. Young.

DR. J. E. YOUNG (Fresno County): Whenever a novice sees a master demonstrate a difficult procedure, he thinks it is easy. I shall try to do the same things Dr. Askey has done. Perhaps in doing so, I will mangle it.

It is the duty in my opinion of every representative person who is in a hall of this kind to represent his constituency, and I am firmly of the opinion it is not the right of any representative in any legislative hall to strengthen the power of the government of which he is a part, but to ever maintain the powers and the rights of his individual constituents. (Applause.)

One of the difficulties we find ourselves in, both locally and nationally, as well as state-wide, is the fact that representatives of their constituents have lost sight of the fact that they represent their constituents, and in so doing they intend to strengthen the hall in which they find themselves.

I am by birth and by choice a Democrat politically, and that birth and that choice are based upon the primary and fundamental concept of that party, the Federal government and all government shall be limited in its powers.

I propose to the best of my ability to see to it that those powers are limited.

Membership within the California Medical Association determines to a large extent whether or not the individual physician shall practice medicine in his locality, and I cannot see that it is a power of this organization to give to itself the right to delve into the pockets of each one of our members and make a contribution to something that is not as yet a component part of our organization or of our profession.

Mr. Chairman, it is my opinion that this motion to raise the dues $25.00, or to amend the motion, is not in order at this time, because it is my feeling that the constituents that I represent are not ready for such a thing, and I do not propose to impose upon them by my vote.

Mr. Chairman, I urge you to defeat this proposition. (Applause.)

VICE-SPEAKER BAILEY: The Chair has no wish to limit debate.

The point at issue at the moment is the amendment as to whether this will be referred to the committee.

Dr. Crane, do you wish to speak to that?

DR. J. J. CRANE (Los Angeles County): I wish to speak against the amendment, but from a different angle.

If you place this proposition up to a vote to the membership at large, and if one man votes against it, you are right back where you are today, gentlemen. They still can raise the question whether it was legal or whether you are taking something away from one man that you shouldn't have taken away from all of us. So, I don't believe that the amendment would solve our problem.

VICE-SPEAKER BAILEY: Dr. de los Reyes, do you wish to speak to the amendment?

DR. DE LOS REYES: Yes, sir.

Mr. Speaker and fellow members: Several years

ago we had a fight in California. Remember that by just one single vote we won a fight against a government that was very much bent on socialistic medicine in California. The Council assessed us $100. Some of us complained. Nevertheless, we defeated it. It was a socialistic tendency in the state of California which was not good for the welfare of medicine.

I believe that we should defeat this amendment, and I am a member of the Council of the Los Angeles County Medical Association. I feel that the least we could do is contribute $25.00 to this great cause. Were we not to do so, we probably would find that this government and those perhaps not in office now, but those that were in office a few months ago, will say that the California Medical Association defeated a resolution that was presented to continue the free choice of the practice of medicine.

I am a Republican by choice. (Applause.) As such I urge you to defeat that amendment, because the least we can do is contribute $25.00 to that fund so we can preserve the right of the private medical schools in this country.

I also contribute to medical schools, but it is not going to hurt me, and it is not going to hurt you to contribute $25.00.

Please, fellows, think what the impact is going to be on the American public and on the American government when they find that the members of the California Medical Association voluntarily or willingly, if you wish, have contributed $25.00 to the welfare of this country and to the welfare of free medicine in the United States. (Applause.)

VICE-SPEAKER BAILEY: The debate continues on the amendment.

The Chair would like to bring the amendment to a vote.

PRESIDENT-ELECT JOHN W. GREEN (Vallejo): May I say just one word?

VICE-SPEAKER BAILEY: Dr. Green.

PRESIDENT-ELECT JOHN W. GREEN: Mr. Speaker, members: The whole thing revolves around one thing; what will Washington and Congress determine is our intent?

It could be very well interpreted on Capitol Hill that our intent in this amendment is to escape our responsibilities. In saying that, I want to refer to the actions of one person, because the amendment has to do something by mechanism, and so forth, refer it to the Council or to some active committee, to get this money on a voluntary basis.

The great state of Nebraska has a very well known surgeon by the name of McGuire from Omaha. Now, Nebraska has also a medical school, Creighton University, as you know, which is not a tax-supported school. But they needed a lot of money. They could not get it on a voluntary subscription basis.

So, one of their members by the name of McGuire went out on his own, and by his personal efforts, calling upon doctors by appointment, knowing his purpose, he got $47,000.

But, gentlemen of this House, will you name me in this House a McGuire?

VICE-SPEAKER BAILEY: Dr. Green is against the amendment. (Laughter.)

Dr. Ward, do you want to recapitulate the important details of this?

DR. ROBERTSON WARD (San Francisco): I would like to very much, Mr. Speaker.

As long as the amendment reverses the original resolution, I think maybe I can talk to it without being out of order.

The discussion before our Reference Committee was whether the Council was morally justified in assigning $100,000 to this fund just on its own judgment.

I think these things should be decided by the grass roots, and I consider this House of Delegates the grass roots of the California Medical Association.

Now, the amendment has referred this back to the county medical society.

We had a good deal of discussion in the Reference Committee meeting as to just how the county medical societies felt about this, and some of them have been canvassed, and they have given their delegates definite instructions. For instance, one of them would go for $25.00, but not more, on this proposition.

So, I don't feel that we are going past the county medical societies when we ask you gentlemen who represent the county medical societies and your districts to vote on this thing. I think we are going back to the grass roots.

I think it would be morally wrong if this had come from the Council as suggested to you. I feel just as Dr. Teall does, that if they weren't being given a chance here in this body to vote for or against this, that it would be morally wrong to add this to the dues. That is why I think the origin of a motion to do this comes legitimately from this body.

The remarks that Dr. Pollock made really don't hold as applied to this motion, because I would like to read to you again the second resolve which takes this away from the tax-supported institutions. I think this is the most important part of the resolve, because I am a graduate of the University of California, and I pay my taxes to support the University of California. I am unwilling to see funds collected in this fashion go to the benefit of the University of California, which is supported by taxes, and I think that is understandable by any of you.

We have tried to eliminate that in this motion, and I will read for you again the second resolve:

Be it further

Resolved, That the dues thus collected be forwarded to the American Medical Education Foundation for distribution among those medical schools which do not receive the major portion of their support from tax sources.

I urge you to turn down the amendment, and vote the resolution.

VICE-SPEAKER BAILEY: Are you ready for the question?

Dr. Askey!

DR. E. VINCENT ASKEY: I would like to move an amendment, sir.

VICE-SPEAKER BAILEY: An amendment to the amendment?

DR. E. VINCENT ASKEY: I move, sir, that this amendment be substituted for the first amendment.

You understand parliamentary procedure, and I don't need to explain it to you, that a motion can be amended twice. This is the second amendment, but by moving it be substituted for the amendment, it takes precedence.

I move that the dues of the California Medical Association be increased $25.00; the Council of the California Medical Association in its best judgment to distribute this money to the best interests of the private, non-tax-supported medical schools for the purpose of the best interests of medical education in America.

... The motion was seconded....

VICE-SPEAKER BAILEY: Dr. Bullock!

DR. L. T. BULLOCK (Los Angeles County): I think everybody here wants to help education; everybody wants to do his part. I think the majority is against enforced taxation. They do not think this is the way to do it.

We can accomplish both of these. We can use the facilities of the California Heart Association to collect this money on a voluntary basis.

I think the best way to do this is to defeat this present amendment and amend it again. Another amendment is not in order at this particular point, but we could change it so that the California Medical Association would send out a request along with the dues for a voluntary contribution of $25.00 by each member.

I think the majority would be happy to do it. I think we would raise the money, and I think we would avoid the aspects of enforced taxation on a matter that is not properly a matter for force within this organization.

I, therefore, recommend this amendment be defeated, and if it is defeated, will propose such an amendment whenever it is in order. (Applause.)

DR. JOSEPH W. TELFORD (San Diego County): I think there has been considerable discussion here which, to me, might very well be continued through the lunch hour in caucus.

Therefore, I would like to move a postponement of action until we reconvene after lunch.

... The motion was seconded....

VICE-SPEAKER BAILEY: Is that a motion to recess at this time, or a motion to lay on the table?

DR. TELFORD: I move to recess at this time.

... The motion was seconded....

VICE-SPEAKER BAILEY: We have a second to the motion, but we have announcements.

... Announcements....

SPEAKER CHARNOCK: When we meet again at 2:00 o'clock, we will meet in executive session for a short period of time. Of course, only delegates and alternates will be admitted to that session.

... Announcements....

VICE-SPEAKER BAILEY: We will go back to the original motion to recess.

Those in favor of recessing at this time until 2:00 o'clock will say "aye."

... The motion was put to a vote and it was carried....

... The Wednesday morning meeting recessed at 12:10 p.m....

Wednesday Afternoon Session

The regular session of the House of Delegates of the California Medical Association was called to order at 2:20 p.m. in the Renaissance Room by Speaker Donald Charnock, who presided.

SPEAKER CHARNOCK: When we recessed for lunch, we were discussing an amendment by substitution to refer to Reference Committee No. 2. Dr. Bailey was struggling with that. We will allow him to do it again. (Laughter.)

VICE-SPEAKER BAILEY: Thank you.

To get back to the situation where we left off, we might ask Dr. Ward to brief us on the original proposition.

Would you like to do that?

DR. ROBERTSON WARD: Yes.

Mr. Speaker, I would like to brief you on the original resolution and on the amendment to the resolution and the substitute resolution.

Am I privileged to do that?

VICE-SPEAKER BAILEY: Yes, you are privileged to talk about the substitute. That is one thing you haven't discussed yet.

DR. ROBERTSON WARD: Well, to go back to the original resolution, I have no desire to change that. I have a desire to say to you that it has been pointed out to me, and I quite agree, that I misinterpreted the original amendment.

The original amendment was not to kill my resolution, but to defer the decision on it until an opportunity had been had to talk it over in the county medical societies.

If this is the intent of the amendment to the resolution, I am not opposed to it.

I thought that bringing it up here was plenty democratic, but I can be convinced by Dr. Teall or Dr. Magoon or anybody else that there are more grass roots maybe than the grass roots right here.

So, the remarks I made against the amendment to my resolution are hereby withdrawn.

Now, I don't suppose I am up here to discuss parliamentary procedure, but I don't think the substitute resolution that took the place of the amendment is really in order, because it doesn't discuss the fundamental thing that the amendment did. It changes the original resolution.

But, my understanding of it is that you can't put in a substitute resolution which considers an en-

tirely different matter, and I bring that to the Speaker as a possible ruling that the substitute resolution be declared out of order.

VICE-SPEAKER BAILEY: Well, there are two things we could do now; declare that out of order, or we could have the entire matter referred to a committee, which would take all the amendments and the original motion.

Dr. Armstrong!

DR. CHARLES D. ARMSTRONG (San Mateo County): Some of the medical schools not now supported by state funds have long since had fund-raising activities of their own, and have begun such fund-raising activities among their alumni.

These activities are apparently not well recognized by the public, including some members of the public who have been elected to the Washington office.

Stanford and Harvard medical schools, to my certain knowledge, have raised sums of money by this means, which may be in excess of that which might be raised by the proposed arbitrary assessment.

Because we need to know many things, and in addition need time for the medical societies at the innermost grass roots level to study this situation, I feel that it is important to find out preferably from the medical schools themselves several things:

First, the amount of contribution from private individuals to the medical schools in question.

Secondly, whether such private gifts may most profitably be given by the individual directly to the school, or by the individual through the channels suggested by the American Medical Association, so that supplementary monies from other sources may be added for the further benefit of the medical schools.

It is for this reason that I should like to make a motion to refer this problem again to Reference Committee No. 2 for a further study and the answer to these questions.

VICE-SPEAKER BAILEY: There has been a motion to refer. Is there a second?

... The motion was seconded....

VICE-SPEAKER BAILEY: This is a motion on the advisability to refer this to a reference committee, and discussion on the question of referring it. Is there any discussion?

Dr. Bender, from San Francisco! This discussion will be on the question of referring the entire problem to the committee.

DR. WILLIAM L. BENDER (San Francisco County): Mr. Speaker, members of the House: I think this matter is too urgent to bury it in committee. I am in favor of giving contributions to the medical schools in order to keep them free and democratic. I believe we are going about it in the wrong way in the original proposition. However, to go to the opposite extreme and bury it at this time is unwise too.

I talk against this resolution which has just been made because I think there is a better way. Once we can clear the board of all these resolutions and amendments we have before us and get a constructive motion consisting of two things, we will be making progress.

The two things are, one, referring it back to the county societies and constituents of our House of Delegates for definitive action relative to an increase in dues.

Number two—in the meantime let us get some action on this as members of the House of Delegates and C.M.A., and make an active campaign to get voluntary contributions, including putting reminders and factual data about the need of this money into the envelopes that the county society sends out for annual dues.

I think that is the approach. We will be studying it. We will be acting on it at the same time.

VICE-SPEAKER BAILEY: Is there any further discussion on this motion to refer?

Dr. Burt Davis, of Santa Clara.

DR. BURT DAVIS (Santa Clara County): I am in agreement with what Dr. Bender says, and I am also totally in agreement with what Dr. Armstrong says. I would like to make a suggestion that we follow Dr. Armstrong's advice and refer this to the committee. If this action is taken, then we may very easily adopt a motion to reconsider the dues as they were established this morning at a point of $65.00, with the provision that the Council, on the advice of this committee, may reduce the dues back to $40.00 if they so indicate.

... The question was called for....

VICE-SPEAKER BAILEY: Dr. Mulfinger.

DR. CARL L. MULFINGER (Los Angeles County): Mr. Chairman, and members of the House of Delegates: This is quite an involved question. It involves a peculiar faith in human nature.

For the past two years it has been my privilege to be a member of the health committee of the Community Chest in this area, and these men are professionals in collecting money to run the Community Chest. If they weren't, they wouldn't be there.

They tell me that only 20 per cent of our population in this area would make contributions voluntarily to anything in the Community Chest.

So, evidently, along the line somewhere, some subterfuge or coercion, or whatever you want to call it, has to be used to get a wider distribution of contributions to these eleemosynary funds.

I think we are in somewhat the same predicament. I think if we left this wide open, 10 or 20 per cent of our members would contribute to their alma mater and help medical education. If we left it alone, the other 80 per cent will be indifferent. I want to bring this point up because I think it is important.

VICE-SPEAKER BAILEY: Thank you.

Dr. Mulfinger is against the motion to refer, I take it.

DR. L. H. FRASER (Alameda County): Mr. Speaker, I agree with Dr. Bender that this should not be tabled. I think the issue is very important.

Here this morning we stressed the dire need of medical schools. If you want to pass this up to the next session, let's quit stalling. If this thing is worth our consideration, let's take some action, wise or unwise, and I think we have enough faith certainly in all of you fine men that we will come up with a wise answer after we have listened to all the deliberations.

I happen to have been a campaign chairman for United Crusade. It so happens that in Alameda-Contra Costa County last year they did something that I think we should consider very seriously when we think of voluntary subscriptions.

The Association took upon itself the task of collecting from all the doctors, and it was arranged through what I thought was a rather clever medium, with the result that the profession not only got 50 per cent more money from the doctors, and willingly, voluntarily, than they have ever given before. But the most important thing I want to talk about is from the standpoint of public relations, because so far your public relations here have not been too good this morning.

We have gotten in a mess and rather than send the mess back to the kitchen, let's see if we can't salvage some public relations.

The program then evolved to the point where the press in Alameda-Contra Costa County was very generous in recognizing the act that the society had done.

Now, my original proposition was this: to come up before you and tell you that we all recognize the need for aid to medical education. But, I think that twenty-five bucks is not enough. I think we are a bunch of pikers when we won't commit ourselves through an addition or a setting of the dues at $25.00.

A lot of us, particularly those that won't give voluntarily, would be happy to sit right there. It would have been a beautiful gesture, and $25.00 would have been it. It will never have a chance, and it will go back to a voluntary contribution.

Now, I recognize the principle involved in the controversy of the compulsory feature of this thing. For that reason, I think the $25.00 should be kept out of the dues. I think that if we want to make a contribution, let's do it.

Or, there is another way to do it, but I am not going to bring it up at this time except to stress this: Somewhere along the line we can salvage some principle of public relations perhaps, by having an assessment. I don't know if I am in order or not.

VICE-SPEAKER BAILEY: You are not.

DR. FRASER: I am talking about the amendment to the amendment.

VICE-SPEAKER BAILEY: You are talking about whether to refer the whole thing to the committee or not.

DR. FRASER: I am talking about referring it to the committee.

As I said before, we shouldn't be pikers. We shouldn't lull ourselves into a sense of security and pass the buck. Let's face this head-on. This is a way we can do it—and again I am speaking against the referring—by voluntary assessment on an emergency basis. But, I can recognize the principle of turning this thing over to the grass roots and the county associations.

The formula that I gave you about the way it was done in Sacramento is a good way. I understand that Alameda-Contra Costa County may well be used to obtaining funds, but the point is I think we should take some action on this and not refer it back to the committee and let it lie dormant for six months.

... The question was called for....

VICE-SPEAKER BAILEY: Is there any further discussion?

Is this on the subject of referring it back to the committee?

DR. THOMAS E. FARTHING (San Mateo County): It is, sir.

Mr. Speaker, I, perhaps, have waited too long, because I had a strong impulse to speak about this sooner, and now you want the question.

I am very glad this is a democratic organization, and I feel there are two principles involved herein.

I think Dr. Teall and others have very eloquently expressed the one that brings us back to the principle of liberty of the individual, and of the individual being given the privilege of deciding about his own philanthropies, and to whom or to what he wants to give his money.

The other, I think, is an angle of public relations, or favorable politics, if you want to call it that. I can't help but sympathize with our delegates whom we send back to the American Medical Association. They have to report such a low amount of money that we have contributed, as if that is all we have contributed. But, it is not all we have contributed. There is a tremendous bulk of contributions that have come from the members of the California Medical Association that have gone in a private way to private institutions, that somehow or another has not been publicized. Whether or not it should be publicized, I don't know.

But I have a feeling that somehow or other we ought to be able to point out that we are supporting medicine, we are supporting medical education in a big way.

This less than one dollar per member is a disgrace, of course. But, that is not the truth. It just so happens that that is one channel through which it has to be expressed, and it appears to be the truth.

Now, why can't we refer this to a committee and let them study some ways of bringing out to the public that we have contributed in large amounts on a private basis?

I am sure the staffs at the universities and all the other private medical institutions in this state could give you almost immediately the amounts of monies they have received through private contributions that have not been publicized.

I have the feeling that I don't want to vote on this issue right now as a delegate to this body, because I would also like to go back to my county society and give them the privilege of thinking about it a little bit.

Also, on the other hand, I feel like Dr. Jekyll and Mr. Hyde. I do not want to pass it off and lose the opportunity to make a favorable impression, perhaps politically or public relations-wise, if you want to call it that. Why can't we refer this to a committee and have them study some means of showing really how much money altogether we have contributed to medical education, including private contributions to private schools, not only those in the state, but those out of the state.

Therefore, I would like very much to favor that we refer this to the committee which Dr. Armstrong has so moved. (Applause.)

VICE-SPEAKER BAILEY: Thank you, Doctor.

Gentlemen, we have taken a long time in debate of this one subject. We have a great many more resolutions. I will call to the attention of the House that if they want to talk about it the rest of the afternoon, they may. If anybody moves to close debate on this, to defer it takes a two-thirds majority to carry, and that takes precedence.

A MEMBER: I so move.

... The motion was seconded....

VICE-SPEAKER BAILEY: It is before the House, and it is not debatable. You understand very clearly, do you, if we close debate on it, it is referred to the committee, and we refer to the committee the main motion, the substitute motion, and everything else.

It takes a two-thirds vote.

This is not debatable. It is a motion to close debate on the question to defer.

Those in favor of closing debate will say "aye."

... The motion was put to a vote....

VICE-SPEAKER BAILEY: The Chair is in doubt. We will have a show of hands.

... The vote was taken by a show of hands, and the motion was carried....

VICE-SPEAKER BAILEY: The "ayes" have it. We have closed debate on the question of deferring.

A MEMBER: I rise to a point of order. Don't we have to vote now upon the question?

VICE-SPEAKER BAILEY: We vote now to refer. We have closed debate. We vote on whether it will be referred to a committee or not. We moved to close debate. We now move whether we shall refer it to committee, or not.

A MEMBER: A point of information. What is the earliest date to which the committee could refer back to this body?

VICE-SPEAKER BAILEY: The Interim Session is the earliest time.

A MEMBER: Mr. Speaker, a point of information. What is this for, to debate or what? A decision was just made on this and a vote was taken.

VICE-SPEAKER BAILEY: A vote has been taken to close debate.

DR. JOSEPH TELFORD (San Diego County): I move to suspend the rules. (Laughter.)

VICE-SPEAKER BAILEY: For what purpose do you move to suspend the rules?

DR. JOSEPH TELFORD: I move to suspend the rules to give to this body a solution to this problem that seems obvious to those on the floor.

VICE-SPEAKER BAILEY: Do you want to give an opinion on that, Mr. Legal Counsel?

MR. HOWARD HASSARD: You have just closed debate on a question that is before the House. You have to vote on the question that is before the House.

... The question was called for....

MR. HOWARD HASSARD: Incidentally, I might add that the introduction of a resolution at this time is not in order, except under the emergency section, and would require a two-thirds vote to introduce an emergency resolution.

... The question was called for....

VICE-SPEAKER BAILEY: I think you will have a chance to bring this up under New Business.

The question before the House is whether we refer to the committee or not.

A point of information, Dr. Ward?

DR. ROBERTSON WARD: Do we not have to set the dues at this meeting? We can't put it off until later.

VICE-SPEAKER BAILEY: They have been set, but under New Business we could reconsider. At the moment we are voting on referring this to the committee.

All in favor of referring this one section of the report to the committee will say "aye."

... The motion was put to a vote....

VICE-SPEAKER BAILEY: We will ask for a show of hands, and the "ayes" are to refer to the committee. This requires a simple majority, you understand.

... The motion was put to a vote by a show of hands....

VICE-SPEAKER BAILEY: We will have to count them. All those who want to refer to the committee will stand and be counted.

We are going back to the "ayes" again.

... A standing vote was taken....

VICE-SPEAKER BAILEY: The "ayes" have it, 119 to 94. (Applause.)

Will you continue your report, Dr. Ward?

DR. ROBERTSON WARD: Mr. Speaker, I move the acceptance of my report in toto as amended. (Laughter.)

VICE-SPEAKER BAILEY: Yes, Dr. Ward. The motion to accept your report in toto as amended is before the House.

... The motion was seconded....

VICE-SPEAKER BAILEY: Those in favor of such acceptance will say "aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER BAILEY: Next is the report of Reference Committee No. 4, Dr. Albert G. Miller, of San Mateo, chairman; Thomas A. LeValley and Dorothy Allen.

Dr. Miller!

REPORT OF REFERENCE COMMITTEE No. 4

DR. MILLER: Mr. Speaker, and members of the House of Delegates: Reference Committeee No. 4, composed of Dr. Dorothy Allen, of Alameda County, Dr. Thomas A. Le Valley, of Los Angeles County, and Dr. Albert G. Miller, of San Mateo County, chairman, offers the following "written report dealing with and making recommendations on all matters submitted to it" in accordance with Chapter V, Section 9 of the California Medical Association By-Laws.

Will you please turn to page 1 of the proposed Constitution and By-Laws resolutions before you. The first one was submitted by Dr. S. J. Shipman of San Francisco. As you see, it is a constitutional amendment, and as such must lie over until the next session for consideration as specified in Article 8, Section 3 of the Constitution.

The next amendment was introduced by A. T. Hinman, M.D., of San Francisco, and it touches on the often-debated subject of the Interim Session of our House of Delegates. This committee thanks the many members who appeared with us to give us their thoughts. By their interest and the show of hands at the first session of the House, we are sure that you want something presented so that a decision will be available to you.

Unfortunately, Dr. Kirchner's substitute resolution presented on Sunday was not mimeographed. However, we felt that with Dr. Hinman's resolution as printed, the salient features of Dr. Kirchner's substitute resolution were included.

During the discussion of the By-Law amendments relating to the Interim Session, it was proposed to our committee that the emergency clause of the By-Laws should be eliminated, that in the future each session, whether annual or interim, should stand on its own feet without carrying over business unless the House so desires and the decision for each year as to whether or not to hold an Interim Session be made by the end of the first day of the Annual Session. We understand that such proposals will be presented to the House in the form of By-Law amendments at the next session.

We therefore propose that the resolution introduced by Dr. Hinman calling for a By-Law amendment changing the methods by which an Interim Session is held, be amended by adding at the outset of the resolution an effective date for the By-Law amendment, such date to be January 1, 1954. As so amended, the introductory part of the resolution reads, "Therefore, be it resolved that effective January 1, 1954, the By-Laws . . . et cetera, et cetera."

The remainder of the resolution setting forth the revised By-Law remains unchanged. The only effect of the committee's amendment is to clarify the situation with respect to the 1953 Interim Session.

The committee at this time recommends that this resolution as amended do pass.

Mr. Speaker, I move the adoption of this portion of the report.

VICE-SPEAKER BAILEY: For the information of the House, that has the effect of keeping the Interim Session in for one more time.

DR. MILLER: That is right. In order to bring these two resolutions to you for your decision, we felt it was not changing the intent to add this amendment, and we could, therefore, deliver it to you in that form.

. . . The motion was seconded. . . .

VICE-SPEAKER BAILEY: It has been moved and seconded that this portion of the report do pass. Is there any discussion?

Those in favor will say "aye."

. . . The motion was put to a vote and it was carried. . . .

DR. MILLER: With your permission, we would like to change the order of the resolutions as printed and consider the resolution of Dr. S. J. Shipman on page 3 of your mimeographed copy. This deals with the elimination of the Standing Committee on Medical Defense, which has been obsolete for many years. Your Reference Committee feels that these deletions should be made and recommends that the resolution do pass.

Mr. Speaker, I move the adoption of this portion of the report.

. . . The motion was seconded. . . .

VICE-SPEAKER BAILEY: Is there any discussion?

Those in favor of the do pass say "aye."

. . . The motion was put to a vote and it was carried. . . .

DR. MILLER: To go back now, please, to page 2 of your copy and the resolution of Dr. Gibbons, of San Francisco.

This pertains to the Medical Services Commission. As you know, this commission was set up at the Annual Session of the California Medical Association in 1952 and its structure and functions were spelled out in specific detail.

The resolution would place the commission under the chapter dealing with committees of the California Medical Association. The only other commissions, namely, Blood Bank Commission and Cancer Commission, are not included or designated as committees and are not named in the By-Laws.

If the Medical Services Commission is to be placed in the By-Laws, it would seem that the two present commissions should be on a similar status. We would recommend that further study be given to the advisability of including these commissions in the By-Laws.

In the case of the Medical Services Commission, it

is our opinion that this commission is so new and its potential for good is so great, that in this stage of its existence it should be allowed the flexibility which it can obtain through direct contact with the House of Delegates and the Council, rather than being handicapped by the restrictive language of a By-Law.

The committee therefore recommends a do not pass.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

VICE-SPEAKER BAILEY: The motion is seconded, do not pass. That will kill this resolution.

Is there any discussion on the question?

Those in favor of killing the resolution by saying do not pass will vote "aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER BAILEY: So ordered.

DR. MILLER: The last resolution on page 3 of your printed copy presented by Dr. J. M. de los Reyes, of Los Angeles, deals with citizenship. The committee feels that the motive behind the resolution is excellent and timely.

At this time the component county societies are still completely autonomous in this matter. As was expressed in the resolution, Los Angeles County for example, already has a definite statement to the effect that their members must be citizens.

In view of opinions expressed by those appearing before the committee, it was felt that the application by the C.M.A. of the requirement to all classes of membership might well be too inclusive. We believe that all active members, those who have the privilege to vote and hold office, should certainly be citizens. To deny all classes of membership to non-citizens may impose a hardship. It could interfere with their hospital affiliations or issuance of professional liability insurance, as five years are required for full citizenship. Citizenship is not required for state licensure by the State Board of Medical Examiners.

Because the changing of the words "all classes" to "active class" would change the intent of the resolution as per our advice from legal counsel, the committee is obliged to recommend a do not pass at this time.

Therefore, Mr. Speaker, we recommend a do not pass, and I move the adoption of this section of the report.

. . . The motion was seconded. . . .

VICE-SPEAKER BAILEY: Once again we have a motion, do not pass, which would defeat the resolution.

Is there any discussion?

DR. J. M. DE LOS REYES (Los Angeles): Mr. Speaker and Fellows: I spoke to our Legal Counsel on the committee, and I am very willing to abide by their decision to change that "all classes" to "active membership," and bring it up before the Interim Session. Thank you.

. . . The question was called for. . . .

VICE-SPEAKER BAILEY: Dr. Askey!

DR. E. VINCENT ASKEY (Los Angeles): A point of order. I hate to disagree with our learned counsel, but if you do not wish to accept all of it, you can accept any part of that which has been suggested.

For instance, if they recommended that the dues should be $5.00, you could make it anything from one to five, but you could not exceed it.

Therefore, in my opinion, sir, it would be all right to reduce this from "all members," to "active members," because that is less than they asked for, and does not exceed. Therefore, the intent of the resolution would not be interfered with.

DR. A. G. MILLER (San Mateo): Then, if we would take Dr. Askey's interpretation of that, I would like to ask Legal Counsel if by the initial resolution being asked to go in a certain section and chapter, whether that would change the intent; what would actually happen if we took that interpretation? I would like to ask Legal Counsel that question.

VICE-SPEAKER BAILEY: Legal Counsel will speak.

MR. HOWARD HASSARD: I regret very much the opinion I have to state, but the By-Laws require that any amendment proposed to the By-Laws must lie on the table for twenty-four hours.

It is, of course, possible to take an amendment that is lying on the table and report it back with minor changes that do not affect the substance.

I agree with Dr. Askey's general statement, but in this particular instance, to shift from membership as such to "active membership," the By-Law amendment has to be changed from an amendment adding a new section to an amendment amending an existing section, and I am afraid that is a substantive change that would defeat the By-Law requirement of the twenty-four-hour wait.

I am sorry.

DR. E. VINCENT ASKEY: I defer, sir.

VICE-SPEAKER BAILEY: In this case, the delay hasn't been quite long enough. (Laughter.)

We will go back to the subject of the question on whether to defeat this resolution by voting "aye" and do not pass.

Is there any further discussion?

Dr. Parker!

DR. LEON PARKER (San Francisco): The gentleman who introduced the resolution told you that he was not a natural born citizen of the United States. I am. In fact, I was so naturally born that early morning the doctor didn't get there, and I slept in. (Laughter.)

I don't know the intent of this resolution. I can't see it. I don't want to be in the position that when I go back to the grass roots in San Francisco to have to tell those interns—fifty per cent of the interns in the common man's hospital in San Francisco, have been foreign in the last two years—that I can't take their application into the county medical society.

I would believe that organized medicine's first job is to educate, and I would believe if there be any undesirable citizens, or people that may not have been citizens among those foreign interns, that they ought to be educated in the medical society.

I think this business of creating a class of foreigners that can't be in organized medicine, is giving ammunition to our worst enemies, both within medicine and without. (Applause.)

VICE-SPEAKER BAILEY: Thank you, Dr. Parker. The "ayes" votes will defeat the resolution. All those in favor of not passing the resolution will say "aye."

... The motion was put to a vote and it was defeated....

VICE-SPEAKER BAILEY: Continue, Dr. Miller.

DR. MILLER: In conclusion, Mr. Speaker, I move the adoption of the report as a whole.

VICE-SPEAKER BAILEY: As amended?

DR. MILLER: Yes, as amended as a whole.

... The motion was seconded....

VICE-SPEAKER BAILEY: It has been moved and seconded. All those in favor signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: I should like to make an announcement before we go on with Reference Committee No. 3.

Dr. Ivan Heron was elected chairman of the Board of the American Academy of General Practice at its national convention in St. Louis in March. I think that is nice recognition for one of our members. (Applause.)

DR. BURT DAVIS (Santa Clara County): Mr. Speaker, I move to reconsider the matter of dues. (Laughter.)

SPEAKER CHARNOCK: It is lost for want of a second.

... The motion was seconded....

SPEAKER CHARNOCK: I am sure you can take this up under New Business.

A MEMBER: A point of order, Mr. Speaker. There was a second that wasn't heard.

SPEAKER CHARNOCK: All right. I will take that, then. I did not hear the second.

It has been moved and seconded that we reconsider the question of the dues.

Is that your motion?

DR. DAVIS: Yes, sir.

SPEAKER CHARNOCK: It has been seconded. Is there any discussion on the reconsideration of the dues?

... The question was called for....

SPEAKER CHARNOCK: It has been moved and seconded we reconsider the question of the amount, I take it, of the dues.

Those who are in favor will signify by saying "aye."

... The motion was put to a vote and it was lost....

SPEAKER CHARNOCK: The motion is lost.

At this time we will have the report of Reference Committee No. 3. Dr. Edward C. Rosenow, Jr., chairman, reporting.

REPORT OF REFERENCE COMMITTEE No. 3

DR. ROSENOW: While they are passing these reports out, I won't bring up anything important until everyone has a copy of this very excellent report. (Laughter.)

At this time I would like to thank the two other members of the committee, Dr. Helen B. Weyrauch, of San Francisco, and Dr. Carl M. Hadley, of San Bernardino County.

The thought that kept recurring to us on this reference committee was that whoever is introducing a resolution might reconsider eliminating about half or all of the whereases and the resolves. In fact, occasionally we had the thought you might not even introduce one at all. (Laughter and applause.)

Before we give this report, I would like to remind you all that whenever possible action is taken, that there is always set up an equal and sometimes even greater amount of reaction. So, I am sure of only one thing from listening to the comments of people who were kind enough and willing enough to give the time to come up and give us their ideas, that at least there will be some people here who are not entirely unfavorable to the Reference Committee's report. Repetition won't enter into it at all.

Do you all have copies now? We can ease into this gradually. The first one or two aren't too bad.

Incidentally, while you are getting those, I might show you these, which are only two of a large number of newspaper clippings that we had at our disposal, and that helped us make some of the decisions we made.

One of them refers to one of the resolutions which I will come to later. The other is about one of the resolutions, in which the "whereas" says that the public is "confused, irritated, and critical of the blood bank program."

This is a telegram from a worker at one of our industrial plants who says:

"As a ten-year man I protest the resolution that a charge be made for the blood donated by the employees of this company blood bank to the Red Cross for the use of these employees and members of their families. I suggest revision of the wording of the resolution."

We have already told him we have reworded the resolution, so I am sure he is no longer "confused, irritated or critical." (Laughter.)

Now, to get to Resolution No. 1. This is a Council-introduced resolution by Dr. Sidney J. Shipman. You all have it in front of you.

Because of some misunderstandings regarding the exact wording of this resolution as presented by the

Council, the committee recommends a substitute resolution reading as follows:

The reason for the misunderstanding and confusion and the rewriting is that the Pathology Section took exception to some of the wording, and this is not essentially to change the meaning of the original resolution, and is as follows:

WHEREAS, It is recognized that well-trained and qualified people with special skills, including those of Ph.D. level, work with doctors of medicine; and

WHEREAS, These people with special skills, regardless of proficiency in a particular field, are, nevertheless, not trained in the over-all skills embraced within medicine and surgery, now, therefore, be it

Resolved, That the medical profession recognize the limit of these special skills but understand the desirability of using such people to measure body functions, by physical or other means, under direction of doctors of medicine; and be it further

Resolved, That in no instance, except where specifically prescribed by law, should these people be permitted to make diagnoses or render diagnoses to doctors of medicine, hospitals, clinics, et cetera; and be it further

Resolved, That such persons with special skills shall not prescribe for the patient, regardless of training but that such prescribing shall be done only by medical doctors and that the care of the people receiving these medicines be under the direction and immediate care of the doctor of medicine so prescribing.

Your committee recommends that this substitute resolution do pass.

Mr. Speaker, I move the adoption of this portion of the report.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that this portion of the report be accepted.

Is there any discussion?

... The question was called for....

SPEAKER CHARNOCK: Those who are in favor of accepting this portion of the report will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is accepted.

Proceed.

DR. ROSENOW: Resolution No. 2 was introduced by Sidney J. Shipman for the Council.

The purpose of this resolution is to provide better coordination and cooperation between the mentioned agencies and your committee recommends do pass.

For your information, these agencies are the Hospital Service of California and the Hospital Service of Southern California, and your committee recommends a do pass.

Mr. Speaker, I move the adoption of this portion of the report.

SPEAKER CHARNOCK: It has been moved that we accept this section of the report. Is there a second?

... The motion was seconded....

SPEAKER CHARNOCK: Is there any question?

Those in favor will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is accepted.

DR. ROSENOW: Resolution No. 3 introduced by Justin J. Stein of Los Angeles.

Your committee feels that this resolution would strengthen the A.M.A.'s action in having Congress study Draft Law 779 and would tend to have Congress adopt the recommendations as suggested by the A.M.A. We, therefore, recommend that this resolution do pass.

Mr. Speaker, I move the adoption of this portion of the report.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that this portion of the report be adopted. Is there any question?

Those who are in favor of adopting this section of the report will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is accepted.

DR. ROSENOW: Resolution No. 4 introduced by Justin J. Stein of Los Angeles.

Parenthetically, I might say we arrived at the conclusion you have before you a rather detailed discussion with our representatives in the public relations field, and at the legislative level in Sacramento. And on their strong urgings, we have adopted this suggestion.

The committee recognizes the importance of civil defense and the intent of the resolution. We believe, however, that so far as the doctors are concerned, they would be ready and willing at all times to take whatever part was deemed necessary in civil defense. It would appear at this time that the public would be better served if the appropriation for civil defense were left to the Legislature. We, therefore, recommend do not pass.

Mr. Speaker, I move the adoption of this portion of the report.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that this portion of the report be adopted.

Is there any question?

We are voting it in the affirmative which will kill this resolution.

Those who are in favor will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: This portion is accepted.

DR. ROSENOW: Resolution No. 5 introduced by Justin J. Stein of Los Angeles.

We recommend that this resolution do pass.

Mr. Speaker, I move the adoption of this portion of the report.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that Resolution No. 5 be accepted.

... There were calls of "what is it about?"...

SPEAKER CHARNOCK: Will you read Resolution No. 5, the emergency resolution introduced by Dr. Justin Stein?

DR. ROSENOW:

WHEREAS, Physicians in the Armed Forces have frequently been used for non-medical duties; and

WHEREAS, The ratio of physicians in the armed forces to personnel is too great; now, therefore, be it

Resolved, That the California Medical Association request of the Secretary of Defense that better utilization of physicians in the armed forces be carried out and that there be a reduction in the amount of non-military medical care and that greater use be made of contract physicians and of existing private medical facilities.

SPEAKER CHARNOCK: Is there any further discussion on this section of the report.

Those who are in favor of accepting this section of the report will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: Resolution No. 7.

DR. ROSENOW: This was introduced by J. M. de los Reyes of Los Angeles.

The need for a straightforward investigation of the social security program is particularly appropriate at this time. Congressmen in the local area have shown interest in such an investigation. However, because the second paragraph adds nothing to the intent of the resolution, we move the amendment of the resolution by deletion of this paragraph and we recommend the adoption of the amended resolution.

Parenthetically, this tends to be a little "inflammatory." That was why we suggested to Joe that he shorten the whereases.

We move the amended resolution do pass.

Mr. Speaker, I move the adoption of this portion of the report.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that we adopt this section of the report. Is there any discussion?

Those who are in favor will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is accepted.

DR. ROSENOW: Resolution No. 8 was introduced by Lyle G. Craig of Los Angeles.

It was introduced as an emergency and refers to the marked shortage of interns available for private hospitals due, in part, at least, to the increasing demands of public, military and veterans' hospitals.

The main principle of this resolution is to keep the door open for provision of good internships in all good hospitals whether private or public, "teaching" or "non-teaching." The resolution points out the limitations and restrictions placed on many hospitals by the Advisory Committee on Internships of the Council on Medical Education and Hospitals of the A.M.A.

Your committee recommends that this resolution do pass.

Mr. Speaker, I move the adoption of this portion of the report.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that we adopt this section of the report. Is there any discussion?

Those in favor will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is accepted.

We move now to Resolution No. 11.

DR. ROSENOW: Thank you very much for your cooperation. It is very gratifying.

Resolution No. 11.

Because of the rapid growth of certain closed panel plans for providing prepaid medical care, along lines which are not in the best interests of the public, this resolution is particularly timely and we recommend do pass.

Mr. Speaker, I move the adoption of this portion of the report.

SPEAKER CHARNOCK: Just one moment, if you please. Legal Counsel has offered an objection.

MR. HOWARD HASSARD: Mr. Speaker, as the resolution is printed on page 6 of the resolutions, it contains a paragraph that I am certain was not introduced.

DR. ROSENOW: You are correct. I am very sorry. This original resolution was printed up before the Reference Committee met. I proofread these things about five times, and I missed that.

The last resolve was not presented in the original part of the resolution. If you will look at the bottom of page 6—

SPEAKER CHARNOCK: Will you please read that?

DR. ROSENOW: It reads, "Resolved, That it is the expressed view of the House of Delegates of the California Medical Association that any member of this Association who participates or practices as a member of a closed panel system in a prepaid medical care plan, such as is hereinabove described, is not acting in a manner to accord with the letter or the spirit of the Principles of Medical Ethics of the American Medical Association."

That was not part of the resolution.

SPEAKER CHARNOCK: Do I hear a second to this?

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and sec-

onded that this resolution as amended be accepted. Is there any discussion?

... The question was called for....

SPEAKER CHARNOCK: Those who are in favor of accepting this portion of the report, Resolution No. 11, will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is passed.

DR. ROSENOW: No. 12 refers to the blood procurement program, and we would like to introduce our substitute for this resolution.

This was introduced by Paul Morton of Santa Clara County.

The Reference Committee feels that the intent of the resolution is fundamental but because the wording in certain portions is confusing, we are submitting a substitute resolution as follows:

WHEREAS, The ready availability of blood and blood derivatives has become a vital necessity to modern medical practice in both the civilian and military populations and therefore a matter of highest concern to the physicians; and

WHEREAS, The independent operation of blood banks of all degrees of excellence throughout the nation by many different agencies, some lay and some medical, has resulted in some confusion and friction between blood banks and organizations operating blood banks; and

WHEREAS, The general public is confused, irritated and critical of the varying methods of operation among blood banks in the same or contiguous areas; and

WHEREAS, The professional aspects of the drawing of blood, its fractionation, and its use as a therapeutic tool, must be under medical control, and such medical control on a national scale logically should be a function of the American Medical Association; and

WHEREAS, The American Red Cross has already been designated by the government as the official blood recruitment and distributing agency for the military services; and

WHEREAS, The present American Red Cross program of so-called "free" blood without requirement for replacement has made collection of adequate supplies for civilian use difficult, has been a tremendous drain on Red Cross funds which might better be devoted to purposes more consistent with Red Cross functions, is inaccurate to the extent that blood is not free but is paid for by the community at large in contributions and by the government through tax revenues; now, therefore, be it

Resolved, That the delegates to the American Medical Association from the California Medical Association be instructed to reintroduce and support in the House of Delegates of the American Medical Association appropriate resolutions pressing for a coordinated national blood bank program jointly operated by the American Medical Association, the American National Red Cross and with the cooperation of other qualified and interested organizations on the following basis:

1. Medical aspects of blood banking shall be under the exclusive control of the medical profession.

2. Business administration, donor recruitment, stockpiling for civil defense and disaster relief, allocation of supplies to meet military needs, and public relations shall be matters of joint concern.

The supply of blood shall be maintained on a replacement basis.

4. The national blood bank program shall be a financially self-supporting but non-profit arrangement operated in the national interest with the sole aim of promoting the widest availability of safe, usable blood and its derivatives.

We move the adoption of the substitute resolution, that it do pass.

Mr. Chairman, I move the adoption of this portion of the report.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that this substitute resolution be accepted. Is there any discussion?

Those who are in favor of accepting this portion of the report signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is accepted.

Resolution No. 14.

DR. ROSENOW: Resolution No. 14. It was introduced as an emergency resolution by Dr. Hinman of San Francisco, and is found on page 9.

Because of the importance of this matter and because the committee feels that this definition as offered in the resolution is somewhat involved and too detailed in its wording, we offer a substitute resolution as follows:

Parenthetically, I may say here since we wrote this, our Reference Committee has met again on this and find it more and more difficult to define this particular phrase, and I think we should all remember that as we define this particular principle, that the more definite the definition is, the more the tendency is to, in some way, restrict the free choice of physician. Therefore, we have added two words, which I will tell you when we get to them.

Resolved, That the definition of the free choice of physicians shall be: "The patient should have absolute freedom to choose a legally qualified physician or surgeon from all of those qualified to practice who are willing to give service under the," and here we want to insert, "lawful and ethical conditions established."

We move the adoption of this substitute resolution. We recommend a do pass.

Mr. Speaker, I recommend the adoption of this section of the report.

SPEAKER CHARNOCK: Do I hear a second?

... The motion was seconded....

SPEAKER CHARNOCK: This is open for discussion.

I may add before any discussion starts, I take it that this change that you have made is just the first resolve? The others are as in the original?

DR. ROSENOW: No, this is the whole thing.

SPEAKER CHARNOCK: The whole thing.

Yes, Dr. Parker.

DR. LEON PARKER: Mr. Chairman, I wish to make a substitute resolution. The whereases in the old resolution would remain as they are.

The definition of "free choice of physician," as was given by your committee with those two words added, would remain as they are. I will, therefore, read the resolution as by the substitute:

Resolved, That the definition of "free choice of physician" shall be: The patient should have absolute freedom to choose a legally qualified physician or surgeon from all of those qualified to practice who are willing to give service under the legal and ethical—as I got your wording—conditions established.

That would be the first resolve.

The second resolve would be:

That the selection of a physician from a closed panel group at the time of purchase of a prepayment plan before the need for treatment of illness or injury does not fulfill the requirement of this definition. And, be it further

Resolved, That this House of Delegates approve the above definition of "free choice of physician" as the only one acceptable in the California Medical Association; and be it further

Resolved, That the Council of the California Medical Association is hereby instructed not to permit any California Medical Association approval, implied or otherwise, of any individual, group, or corporation, dealing in medical services or insurance unless free choice of physician is exercised according to this definition; and be it further

Resolved, That the Council of the California Medical Association is hereby further instructed to use all reasonable effort to inform and instruct the public in the basic tenets of this resolution.

SPEAKER CHARNOCK: Is there a second to this amendment by substitution?

... The motion was seconded, and the question was called for...

SPEAKER CHARNOCK: Is there any discussion on this?

Dr. Dozier!

Dr. Dozier, you are to discuss this amendment by substitution?

DR. DAVE F. DOZIER (Sacramento County): I should like to ask the privilege, Mr. Chairman, to introduce a substitute for the amendment.

... The question was called for...

SPEAKER CHARNOCK: Well, this is a secondary amendment already. The Reference Committee has amended it once. This one is the second one. So, that would be the third, and not allowed.

DR. DAVE F. DOZIER: May I speak to it?

SPEAKER CHARNOCK: You may speak to the amendment by substitution which has just been presented.

DR. DAVE F. DOZIER: Gentlemen, I feel we have two things involved here; one, a matter of principle, and I think we are thoroughly and completely united on the principle of free choice of physician.

The second thing we have is as indicated in the committee's report, a matter of definition. How do we define "free choice of physician"?

That involves a rather profound medical and legal thought. Certainly any definition of "free choice of physician" that we will be asked to furnish must be a good one, and it must have no loopholes in it.

I feel that if this House can at this time simply go on record as being unanimously in favor of the principle of "free choice of physician," that the exact definition which can then be presented to the public, and which can then be presented to our members, should be left for further study.

I don't think that we as a deliberative body are ready at this moment to write out a definition which is going to be wholly satisfactory from the standpoint of either our public relations, our legal department, or from the members themselves.

We don't want to get into a bind with resolutions on top of resolutions here. If it were to occur that the amendment as offered would be defeated and that the recommendation of the committee then come up for amendment again, I would like to offer a resolution stating that we affirm—take that part of the resolution and affirm our endorsement — our complete endorsement of the principle of free choice of physician, and that then the definition be left to the Medical Services Commission to be reported later in such a manner as can be best attained by consultation with Mr. Hassard, and whoever else is interested.

SPEAKER CHARNOCK: Dr. Dozier, would you like to move to refer this entire section of the report to the Medical Services Committee? That is in order.

DR. DOZIER: Mr. Speaker, I think that would miss one point from the standpoint of publicity and public relations today. Certainly we ought to go out of here waving the banner of "free choice of physician."

If we refer the whole thing, that thing is lost as far as publicity is concerned.

I do think we should be able to work out the thing here without spending too much time on it, whereby we can stick by that principle and let the legalists furbish it up as to the exact definition.

DR. LEON PARKER (San Francisco County): Mr. Chairman.

SPEAKER CHARNOCK: Dr. Leon Parker.

DR. LEON PARKER: This resolution was not intended as an emergency. It was brought here, not to be an emergency, and the people that worked on it particularly didn't ask that it be an emergency, but

not knowing whether we are going to have an Interim Session or not, it got pushed in here.

Therefore, I am going to move to refer this to Committee No. 3, to be reported back to us at the Interim Session.

SPEAKER CHARNOCK: Is there a second to that?

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that this section of the report be referred back to Reference Committee No. 3, that it be reported at the Interim Session.

Is there any discussion?

... The question was called for....

SPEAKER CHARNOCK: There being no discussion, all those who are in favor of referring this section of the report will signify by saying "aye."

... The motion was put to a vote....

SPEAKER CHARNOCK: The Chair is in doubt.

Those who are in favor of referring this report will please raise their hands.

... The vote was taken by a show of hands, and it was carried....

SPEAKER CHARNOCK: The "ayes" have it, and it has been referred back to Reference Committee No. 3.

Will you proceed? No. 15.

DR. ROSENOW: I might say that Reference Committee No. 3 would be happy to have any of you write a definition of "free choice of physician," to us between now and the Interim Session, so we can be helped in this rather complicated problem.

Next is No. 15.

This resolution refers to better cooperation between the professions of osteopathy and medicine.

This resolution, introduced at the request of the C.M.A. Committee studying the relationship of the two professions, would reaffirm last year's resolution and help to hasten the time of greater cooperation between the two professions. Your committee feels that such cooperation is important in the public interest and recommends that this resolution do pass.

Mr. Chairman, I move the adoption of this section of the report.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that this section of the report be adopted. Is there any discussion?

Those in favor will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is adopted.

DR. ROSENOW: Resolutions Nos. 16 and 20, introduced by L. Henry Garland of San Francisco and Robertson Ward of San Francisco, respectively.

Inasmuch as resolutions 16 and 20 both refer to the care of veterans and particularly with reference to non-service-connected disabilities, the committee recognizes the need for a change of policy regarding this problem and submits a substitute resolution for both of these resolutions, as follows:

WHEREAS, The highest quality of medical care and rehabilitation of service-connected disabilities in veterans is an undisputed obligation of the Federal Government and a basic requirement of long-term defense; and

WHEREAS, This should be the first responsibility of the Veterans Administration medical program; and

WHEREAS, In most communities local health facilities are adequate for treatment and rehabilitation of non-service-connected disabilities; and

WHEREAS, Economy is usually given as the excuse for the Veterans Administration not affording physicians in the home town program with the veterans' service medical records or records of treatment of the Veterans Administration or otherwise; and the lack of such records deters the best medical care and rehabilitation of the veteran as well as working a hardship on the physician; and

WHEREAS, The present Veterans Administration laws state that non-service-connected illnesses will be cared for by the Veterans Administration "if the individual signs an oath that he is unable to pay for private medical care"; and

WHEREAS, Such violations could be eliminated if a more accurate definition of eligible beneficiaries were defined in the law; now, therefore, be it

Resolved, That this House of Delegates instruct our Delegates to the American Medical Association to introduce and sponsor resolutions that will set up a program of study which will aid Congress to:

1. Continue the policy of the A.M.A. of advocating the best medical care and rehabilitation of service-connected disabilities.

2. Eliminate false economy measures in home town treatment programs and furnish the home town physician with military and Veterans Administration medical records.

3. Eliminate waste in the treatment of non-service-connected disabilities, by defining a "beneficiary" sufficiently well so that the offenders could be apprehended in order to prevent the expansion of facilities for care of non-service-connected disabilities.

4. Consider the eventual elimination of the use of Veterans Administration hospitals as domiciliary establishments so prone to work against rehabilitation.

5. Exercise all further economy possible with the Veterans Administration to prevent the expansion of facilities for care of non-service-connected disabilities.

Your committee recommends the substitute resolution do pass.

Mr. Speaker, I move the adoption of this portion of the report.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that this substitute resolution will take the place of Resolutions 16 and 20.

Is Legal Counsel in agreement? Is that satisfactory?

MR. HOWARD HASSARD: Yes.

SPEAKER CHARNOCK: Is there any discussion?

... The question was called for....

SPEAKER CHARNOCK: Those in favor of accepting this portion of the report will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is accepted.

DR. ROSENOW: The next resolution to be considered is No. 18. It is an emergency resolution. It refers to the publicity regarding the American College of Surgeons and one of its spokesmen. It is on page 12 of your original resolutions, and your committee recommends that the following paragraph be added to the resolution as submitted:

Be it further

Resolved, That the American College of Surgeons and its spokesmen be reminded, in the public interest, that there already exist adequate methods for correction of such alleged abuses through the constituted channels of the American Medical Association and its component societies.

Incidentally, I would like to point out this newspaper clipping refers to a resolution that has been adopted by the Illinois State Medical Society House of Delegates which has two points to it:

One, inquiry and disciplinary action against Dr. Hawley by the American Medical Association, and two, remedial measures by the American Medical Association against the American College of Surgeons.

So, we are not alone in this.

We recommend this amended resolution by the addition of the second resolve do pass.

Mr. Speaker, I move the adoption of this portion of the report.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that the adoption of this section of the report as amended be accepted.

Is there any discussion?

Those in favor will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is accepted.

DR. ROSENOW: The last resolution is No. 21, introduced by Albert G. Miller of San Mateo.

This refers to the so-called Bricker resolution.

Your committee agrees completely with the resolution as presented but would like to make a slight change so that the last two paragraphs now read:

Resolved, That our Delegates to the A.M.A. alert the A.M.A. House of Delegates to this particular problem; and be it further

Resolved, Specificially that we and our Delegates to the A.M.A. heartily endorse and urge every member of Congress to adopt Senate Joint Resolution No. 1, the Bricker Resolution.

Your committee recommends that this amended resolution do pass.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that we adopt this section of the report. Is there any discussion?

... The question was called for....

SPEAKER CHARNOCK: Those who are in favor of accepting this section of the report will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is accepted.

DR. ROSENOW: Mr. Speaker, I move the adoption of the committee's report as a whole as amended.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that the report of Reference Committee No. 3 as amended be accepted. Is there any discussion?

... The question was called for....

SPEAKER CHARNOCK: Those who are in favor will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is accepted.

We wish to thank Dr. Rosenow, Dr. Helen Weyrauch and Dr. Carl Hadley for their work on Reference Committee No. 3.

DR. ROSENOW: I want to make one announcement, that there are five or six resolutions left over to be acted upon at the Interim Session.

One of the original purposes of having an Interim Session is to have more time to study the resolutions. I hope all of you will read the resolutions we have not presented today, and will feel very free to write the committee about any further changes you would like. (Applause.)

SPEAKER CHARNOCK: Thank you, Dr. Rosenow, and your committee.

The next order of business is the report of Reference Committee on C.P.S. Business. Dr. Thomas N. Foster of Santa Clara, chairman.

REPORT OF REFERENCE COMMITTEE ON C.P.S. BUSINESS

DR. FOSTER: Mr. Speaker, members of the House: Your C.P.S. Reference Committee, composed of Drs. Norton Donaldson, Paul Foster, and myself, has met and considered the items of business referred to it. They were:

1. The report of Reference Committee No. 1, with proposed amendment by Dr. Samuel R. Sherman, of San Francisco.

2. Resolution introduced by Dr. Allen T. Hinman, of San Francisco.

At the request of Dr. Sherman, reference to the cost of living index in his amendment was deleted, since this was but one of several factors involved in fee list revisions. Dr. Sherman's amendment now reads:

"That at any place in the C.M.A.-C.P.S. Study Committee Report where reference is made to a fee schedule or fee list, it be understood that such fee schedule or fee list shall be subject to review and revision at least every two years, using the same mechanism as provided for in the original report."

Mr. Speaker, I move the adoption of this portion of the report.

SPEAKER CHARNOCK: Do I hear a second?

... The motion was seconded. ...

SPEAKER CHARNOCK: It has been moved and seconded we adopt this portion of the C.P.S. Reference Committee report. Is there any discussion?

Dr. Julius Kahn, of Los Angeles County!

DR. JULIUS KAHN (Los Angeles County): I just want to ask a question. Does this report recommend the publication of a fee list, fee schedule?

DR. FOSTER: I think that is premature, isn't it, Doctor? We haven't got to that portion of the report.

DR. KAHN: But it does—

DR. FOSTER: We are talking now about Dr. Sherman's amendment that if a fee list should be undertaken, it would be revised at least every two years. It doesn't say a fee list will or must be undertaken.

DR. KAHN: Thank you.

SPEAKER CHARNOCK: Dr. Kahn, we just haven't gotten that far along yet.

Is there any discussion on this section of the report?

Those who are in favor of accepting this section of the report will signify by saying "aye."

... The motion was put to a vote and it was carried. ...

SPEAKER CHARNOCK: It is accepted.

DR. FOSTER: Your C.P.S. Reference Committee, like Reference Committee No. 1, is also impressed by the very thorough investigation of the problems of health insurance and the dynamic new concept evolved by the C.M.A.-C.P.S. Study Committee. The medical profession and the public have been well served by the physicians on this committee. To our knowledge, no group of physicians in the history of medicine has so intensively undertaken to devote their time, effort and thought toward the equitable distribution of medical care. We believe this is concrete evidence of the desire of the profession that medical economics advance in step with medical science.

The committee meeting was exceptionally well attended. Present were members of the C.M.A.-C.P.S. Study Committee and the Medical Services Commission. Present also—and this, we believe, is of particular import — were many Delegates whose component societies have been actively investigating the practical application of the new principles.

There has been much progress in the implementation of these new concepts. In the few months which have elapsed since the December Interim meeting when the C.M.A.-C.P.S. Study Committee report was first offered to the House of Delegates, countless sessions have been held by the county societies, first to acquaint the members with the philosophy of the report, then to consider each step in its application as it relates to the local situation.

Several counties already have sufficiently crystallized the information gained through their investigations so that they are approaching the inauguration of a pilot basis, so that as test data is obtained, other societies will benefit by the experience.

At the completion of full discussion, and the discussion was very full, of all points of view, it was the unanimous opinion of all delegates in attendance at the hearing that the Study Committee recommendations should be submitted to the Medical Services Commission for continuing active study, and that pilot plans should be encouraged in order that practical experience in the operation of such a program may be gained. We believe that this course of action is the best assurance that the public's interests will be best served.

This committee is in full accord with the recommendations of Reference Committee No. 1 as amended.

Mr. Speaker, I move the adoption of this portion of the report.

... The motion was seconded. ..

SPEAKER CHARNOCK: It has been moved and seconded that this portion of the report be accepted. Is there any discussion?

... The question was called for. ...

SPEAKER CHARNOCK: Those who are in favor will signify by saying "aye."

... The motion was put to a vote and it was carried. ...

SPEAKER CHARNOCK: It is accepted.

DR. FOSTER: The other resolution referred to the C.P.S. Reference Committee was that introduced by Dr. Allen T. Hinman of San Francisco.

With the approval of Dr. Hinman, minor changes in wording were made which did not alter the intent of the resolution. The resolution now reads:

WHEREAS, Current changes in the economics of the practice of medicine are fully recognized; and

WHEREAS, It is the responsibility of the medical profession to take the leadership in the formulation of standards of health insurance; it is hereby

Resolved, That because of the wealth of material and considered conclusions presented, the C.M.A.-C.P.S. Study Committee Report should be kept fresh and vital in our minds as a source of information and as a guide in our continuing efforts to develop

sound and equitable means of insurance against the cost of illness; and

That we reaffirm the objective of C.P.S. to serve as a means for developing better methods of prepaid health insurance; and

That in order to obviate the necessity of any unsavory police system among us and to minimize the dissipation of insurance benefits through misuse and over-use, we should broaden the accepted principle of patient participation in meeting the cost of illness with co-insurance, particularly on a percentage basis; and

That this House of Delegates urge our Council, the Board of Trustees of California Physicians' Service, and the Medical Services Commission to use their good offices to foster and to continue the work which the C.M.A.-C.P.S. Study Committee has engendered.

Mr. Speaker, I move the adoption of this portion of the report as amended.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that this section of the report be adopted as amended.

Is there any discussion?

... The question was called for....

SPEAKER CHARNOCK: Those who are in favor of adopting this section of the report will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is accepted.

DR. FOSTER: Mr. Speaker, I move the adoption of the report as a whole.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that we adopt the report as a whole. Is there any discussion?

Those who are in favor of accepting this report as a whole will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is accepted.

We wish to express our thanks to Dr. Foster, Dr. Donaldson, and Dr. Paul Foster for their work on this committee. (Applause.)

The next order of business is unfinished business. Mr. Secretary?

SECRETARY DANIELS: There is none.

SPEAKER CHARNOCK: The Secretary announces there is no unfinished business.

The next order of business is new business.

During this time, if anybody would like to put up a resolution that would be carried by two-thirds, you have that power.

DR. JOSEPH W. TELFORD (San Diego County): Mr. Chairman.

SPEAKER CHARNOCK: Yes.

DR. TELFORD: This is a new resolution that I believe should not be an emergency.

SPEAKER CHARNOCK: If it is not an emergency, we can't accept it.

DR. TELFORD: All right, I will declare it an emergency.

WHEREAS, It is obvious to all members of the California Medical Association that there is a definite need for funds to support medical schools who do not receive adequate funds from tax sources; and

WHEREAS, It is also obvious there is a very definite urgency that we meet without delay this obligation on the part of organized medicine to meet this financial need of our medical schools; and

WHEREAS, California medicine is dedicated to the principles of free enterprise, the recognition of the morality of its membership and the abhorrence of compulsion; and

WHEREAS, Assessment will not only interfere with our principles, but may well upset the previously well-established programs of the alumni organizations of the medical schools; and

WHEREAS, We are exceedingly anxious to implement the voluntary contributions to medical education, we believe that by the reaffirmation of our principles that we may very well actually achieve a more productive fund in years to come; now, therefore, be it

Resolved, That the present C.M.A. Educational Fund Committee be given the means whereby they may execute a more effective program at the county levels, and that each component county society notify its membership that this House of Delegates recommends a donation of at least $25.00 annually per member. We further recognize the work already accomplished by the C.M.A. Auxiliaries in this program, and we recommend continued and increased participation by our Auxiliaries. (Applause.)

SPEAKER CHARNOCK: Do I hear a second to this?

In order to accept this as an emergency motion, it will be necessary for you to vote by a two-thirds majority to accept it, first of all.

May I hear a motion to accept this as an emergency motion?

... It was moved and seconded that this be considered an emergency motion....

SPEAKER CHARNOCK: It has been moved and seconded that we accept this as an emergency measure. Is there any discussion?

All those in favor will signify by saying "aye."

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is accepted as an emergency motion.

It has been moved and seconded. Is there any discussion?

... The question was called for....

SPEAKER CHARNOCK: If there is no discussion to

this motion, those who are in favor will signify by saying "aye."

... The motion was put to a vote and it was carried. ...

SPEAKER CHARNOCK: It has been passed unanimously. (Applause.)

Is there any further new business? If there is no further new business to come before this House, we will pass on to the next order of business.

The next order of business is the presentation of the new officers.

PRESENTATION OF NEW OFFICERS

DR. ALESEN: Mr. Speaker, members of the House of Delegates: It is with extreme pleasure that I present your new President, Dr. John W. Green of Vallejo. (Standing applause.)

PRESIDENT JOHN W. GREEN (Vallejo): Thank you, President Lewie.

Members of the House: I am sure you have heard about all you want to hear from me today. I made my big pitch. I thank you for its reception. I thank you for its final disposition. Now I hope that I can thank you for putting it into activation.

There was something said once to me by one of our old professors that made me think that sometimes brevity is very unusual. We had a professor of venereal diseases by the name of William T. Belford at Rush Medical College some years back.

His first address before the junior and senior sections was a little bit late in materializing. He was delayed somewhere, and came in in his Prince Albert coat, his silk hat and his gloves, put his hat on the table, took off his gloves and put them there.

"Gentlemen," he said, "I have a very interesting subject for discussion this morning." He said, "I refer to that disease called syphilis." He said, "Suspect your grandmother."

With that, he turned and walked out, and that was one hour's lecture.

My remarks are going to be just that brief. I hope, ladies and gentlemen, as one doctor said in San Francisco not too long ago—a gentleman by the name of Bender—he said in a little thing that he wrote that he hoped we would remember the Golden Rule that has to do with doctor-patient relationships, and doctor-to-doctor relationships. Please bear that in mind.

One other thing, very short: I don't believe it has been too customary over this state for doctors in general practice referring patients to specialists, to particularly inform the doctor to whom the patient is referred of the things that have already been done for the patient, and the opinions that have been expressed concerning them.

So, I would say this: that we might help our public relations a little bit as far as patients are concerned if we wouldn't do those laboratory procedures over and over again which have already been done, and which cost money in these times.

I will do the very best I can to serve you this year. I thank you for all your kindnesses. (Applause.)

DR. ALESEN: Thank you, John.

Now, ladies and gentlemen, your new President-Elect, Dr. A. A. Morrison of Ventura. (Standing applause.)

PRESIDENT-ELECT MORRISON: Thank you, Lewie.

I have been to enough of these meetings that I know the only thing you want at this time is for me to shut up, get to work, and let you go home.

Thank you very much. (Applause.)

DR. ALESEN: Your Speaker isn't new, but he is each year renewed with a brand new fire, Dr. Donald Charnock. (Applause.)

SPEAKER CHARNOCK: Thank you. We are still fighting out this resolution over here. (Laughter.)

DR. ALESEN: Now, once more, that very capable parliamentarian, Dr. Wilbur Bailey, your new Vice-Speaker. (Applause.)

VICE-SPEAKER BAILEY: This is a job you never get done perfectly, but we are glad to keep on trying.

SPEAKER CHARNOCK: Now, the next order of business is to have Dr. MacLean come up to the platform to present a certificate to the retiring President.

Dr. MacLean!

PRESENTATION OF CERTIFICATE TO RETIRING PRESIDENT LEWIS A. ALESEN

DR. MACLEAN: Mr. Speaker, members of the House of Delegates: There are some very nice things about being a retired President or a Past-President. This happens to be one of those things.

I have the honor now to tell Dr. Alesen, our retiring President, how much we appreciate his efforts.

Dr. Alesen, I am sure I express the sentiments of everybody in this House of Delegates and the entire membership of the California Medical Association when I tell you we certainly appreciate all your untiring efforts and your very dynamic leadership; not your efforts alone in promoting good medicine, but your efforts in the great fight for freedom and liberty.

I now would like to give you this plaque. (Standing applause.)

RETIRING PRESIDENT ALESEN: Mr. Speaker, my friends and fellow practitioners: Could I have just a minute or two to sing a swan song?

... There were calls of "sure." ...

RETIRING PRESIDENT ALESEN: The highest honor in California medicine you accorded me two years ago. At that time, I was a very happy man. Tonight I also am happy. That happiness is tinged with just a bit of nostalgia for passing associations.

If I had the tongue of Demosthenes I would paint in glowing terms my visits from Yreka to San Diego. But time does not permit.

I do want to tell you that wherever I have gone I have always been met with friendliness and good will; not always with total agreement, but certainly you have been cooperative.

Never in my experience have I found more men of better good will, devoted to the cause of giving to their patients a high grade of medical care.

Now I am reminded, Mr. Speaker, of Marie Corelli's famous book, "Thelma." As I say good-bye to the office of President of the California Medical Association, like Marie Corelli's hero, who got into his little barque at sunset and set his sail to the west, and then set fire to his barque, I would like to say, sir, "Sic transit gloria mundi." (Applause.)

SPEAKER CHARNOCK: There is just one more little gesture, sir.

... Speaker Charnock attaches a pin on Dr. Alesen's lapel....

DR. ALESEN: Thank you. (Applause.)

SPEAKER CHARNOCK: This House is still in session, and is still open for business.

Dr. Robertson Ward has asked permission to propose another resolution, and I will let him present it to you and see if you wish to declare it an emergency.

DR. ROBERTSON WARD: Mr. Speaker, as long as the good old ship hasn't touched bottom, all is not lost.

I would like to introduce a resolution prepared in the last session of my committee, which is going to have to deal with this problem over the next year; I can see that. There is no way of getting out of it.

But, in the meantime, we would like to facilitate voluntary contributions to the American Medical Education Foundation, and for that reason we ask permission to introduce this as an emergency resolution, and to ask for your action on it at the present time.

No whereases.

Resolved, That each county medical society be requested to form a committee to obtain voluntary donations to the American Medical Education Foundation, and that the California Medical Association, through its Council prepare and send to each component county medical society a form to be included with the bill for dues, requesting contributions to the fund, and a report of what that individual doctor has given to his own medical school, and that this form be sent directly to each member when his bill is sent.

Now, that is the resolution in fairly simple words, and I am sure you can see my reason for introducing it, because even while we are making the decision as to whether this will eventually become dues or an assessment, we don't want to lose this opportunity to put California out in the front of voluntary contributions.

Mr. Speaker, I move the adoption of this resolution.

... The motion was seconded....

SPEAKER CHARNOCK: This will have to be an emergency, and may I hear a motion to declare this resolution an emergency?

DR. ARTHUR A. KIRCHNER (Los Angeles): I so declare.

... The motion was seconded....

SPEAKER CHARNOCK: It has been moved and seconded that we declare this an emergency. Is there any discussion?

... The motion was put to a vote and it was carried....

SPEAKER CHARNOCK: The resolution of Dr. Ward has now been moved and seconded, and is now open for discussion.

A MEMBER: A point of information.

SPEAKER CHARNOCK: What is your question, please?

THE MEMBER: Won't this resolution set up another mechanism than the other one we just voted on a while ago?

SPEAKER CHARNOCK: It is practically the same thing. It is a supplementary procedure.

Is there any discussion of this?

Dr. Bender!

DR. WILLIAM L. BENDER (San Francisco County): Mr. Speaker and fellow members: I think one of the things we lacked here today was factual information about this fund and these collections. We don't know how much the medical schools really need. We don't know how much they collect independently. We don't know how many non-tax-supported schools there are in the country.

I don't believe this is necessary in the form of an amendment, but I would suggest that when the implementation of Dr. Ward's resolution is made, should the resolution pass, that any requests relative to contributions be accompanied by adequate data on the background, and the financial status and the needs of these particular schools.

SPEAKER CHARNOCK: Dr. Ludwig, have you any discussion to give on this resolution?

A MEMBER: Could I ask a question? What does this resolution add to the one we have already passed? I can't see that it adds a thing.

DR. ROBERTSON WARD: Mr. Speaker, may I answer that?

SPEAKER CHARNOCK: You may answer.

DR. ROBERTSON WARD: I presented this resolution because it gives our Council a chance to start right now to call for voluntary contributions.

... There were calls of "that is what the other one did."...

DR. ROBERTSON WARD: The other resolution referred this to my committee.

A MEMBER: You missed a resolution.

DR. L. H. FRASER: I think the confusion arises out of the fact Dr. Ward was out of the room when the other resolution was passed.

DR. ROBERTSON WARD: I didn't know that.

SPEAKER CHARNOCK: We will have Dr. Daniels speak to that.

SECRETARY DANIELS: I would like just to add that for at least a bookeeping record, the implementation of at least a portion of Dr. Ward's request would give the C.M.A. an actual knowledge of how much money is being contributed by its members, if that information is considered of value.

Now, I think it would be very nice for us to have that information if the doctors would fill out these yellow cards, or whatever would be sent out with their dues, as to how much they gave. It would give us valuable information to go on.

SPEAKER CHARNOCK: My opinion about this resolution of Dr. Ward's is that it is a supplement to the other resolution. About the only thing I picked up of difference was the fact that it would turn in the amount of money that was being subscribed.

DR. ROBERTSON WARD: I wish to apologize to the House, because I was out cooking this up while the other resolution was introduced. So, I didn't know what you were talking about. (Laughter.)

I do think all this would add to the other resolution is the opportunity to collect some information, and if that is included in the previous resolution, mine is entirely out of order.

SPEAKER CHARNOCK: Well, that particular point of information, I take it, was not included in the other one. So, I think this is a supplemental resolution. That would be satisfactory as a supplemental resolution.

... The question was called for....

SPEAKER CHARNOCK: Those in favor of this resolution will signify by saying "aye."

... The motion was put to a vote and it was carried....

... Announcements....

SPEAKER CHARNOCK: A motion to adjourn is in order.

... It was moved, seconded, and passed that the meeting be adjourned. The meeting adjourned at 4:20 p.m....

Council Meeting Minutes

Tentative Draft: Minutes of the 399th and 400th Meetings of the Council of the California Medical Association.

399th Meeting

The meeting was called to order by Chairman Shipman at 9:30 a.m., Saturday, May 23, 1953, in Conference Room 8 of the Biltmore Hotel, Los Angeles.

Roll Call:

Present during all or a part of the meeting were President Alesen, President-Elect Green, Speaker Charnock, Vice-Speaker Bailey, Secretary Daniels, Editor Wilbur and Councilors West, Wheeler, Loos, Sampson, Morrison, Dau, Ray, Montgomery, Lum, Bostick, Pollock, Frees, Carey, Shipman, Kirchner, Varden and Heron.

A quorum present and acting at all times.

Present by invitation at all or a part of the meeting were Messrs. Hunton, Thomas, Clancy, Gillette and Pettis of the C.M.A. staff; legal counsel Hassard and Louis M. Welsh; Messrs. K. L. Hamman and Marshall Virello of California Physicians' Service; Mr. Thomas Hadfield of American Mutual Liability Insurance Co.; county society executive secretaries Waterson of Alameda, Geisert of Kern, Bannister of Orange, Watson of Sacramento, Nute of San Diego, Thompson of San Joaquin, Wood of San Mateo, and Donovan of Santa Clara; Mr. Ned Burman of public relations counsel; Mr. Charles Horton, insurance analyst; and Doctors John R. Upton, Edwin L. Bruck, Sam J. McClendon, Francis J. Cox, Wilton L. Halverson, H. Gordon MacLean, Donald Cass, Leslie B. Magoon, Paul Foster, E. Vincent Askey, Burt Davis, Eugene F. Hoffman, Carl Hadley, Frederic Ewens, Elmer E. Wadsworth, Dan O. Kilroy, Edward C. Rosenow and R. Stanley Kneeshaw.

1. *Minutes for Approval:*

On motion duly made and seconded, minutes of the 398th Council meeting, held February 22, 1953, were approved.

2. *Membership:*

(a) Report of membership as of May 16, 1953, was received and ordered filed.

(b) On motion duly made and seconded, one 1952 delinquent member and 379 members delinquent in 1953, dues now paid, were voted reinstatement to active membership.

(c) On motion duly made and seconded, in each instance, 12 members were elected to Retired Membership. These were:

Alfred C. Siefert, Alameda-Contra Costa; C. H. Lauder, Orren Lloyd-Jones, and F. T. Read, Los Angeles; T. Binkley, Sacramento County; Frank X. Fiegel and Frank H. Folkins, San Bernardino; Matilda A. Feeley and William G. Moore, San Francisco; George W. Fowler, Santa Clara; Ernest H. Nast, Santa Cruz; C. C. Dickinson, Siskiyou.

(d) On motion duly made and seconded in each instance, 34 applicants were elected to Associate Membership:

E. Kleona Brown, T. R. Meagher, John R. Philp, James G. Terry, and Louis S. Wilson, Alameda-Contra Costa.

Patricia Henderson, H. Robert Ripley, and Elizabeth Young, Fresno County.

Ernestine Janzen and Jacob Janzen, Los Angeles County.

Arnold Shamaskin and Lee A. Stone, Madera County.

E. David Akers and Carolyn B. Albrecht, Marin County.

George Loye, Napa County.

Thomas P. Reeder, Orange County.

David R. M. Harvey and G. W. Shannon, Riverside County.

I. O. Church, Sacramento County.

Turner Camp, R. E. Clausen, Jr., Elmer Galioni, Hedda Kornfeld, John R. Mitchell, Charles F. Naegele, Robert P. Ralls, and James Yee, San Francisco County.

John Batke, San Joaquin County.

Paul Kotin, San Luis Obispo County.

Donald L. Alcott, Ernest E. Clark, Marceli Kawalek and David McKell, Santa Clara County.

R. Davis Roadruck, Sonoma County.

(e) On motion duly made and seconded in each instance, 40 applicants were voted leaves of absence.

(f) Report was made on the filing of an appeal with the A.M.A. Judicial Council by a member of the Alameda-Contra Costa Medical Association, whose revocation of membership by the county society had previously been affirmed, on appeal, by the Council. On motion duly made and seconded, it was voted to appoint Dr. Lester Lawrence as the Association's representative in this action before the A.M.A. Judicial Council. Dr. Lawrence will represent the county also.

3. *Legal Department:*

Mr. Hassard reported that a bill had been signed by the Governor to permit the Board of Medical Examiners or a group of ten or more physicians licensed by that board to seek court injunctions to prevent alleged illegal practices. He suggested that a special committee of at least ten members be established to function in this capacity, similar to a comparable committee in the state bar association.

On motion duly made and seconded, the chairman appointed Drs. Wilbur (chairman), Morrison and Bailey to investigate this proposal and report back at a recessed meeting. Upon the report of this committee, it was duly moved, seconded and voted to establish a Committee on Unlawful Practice of Medicine, such committee to consist of the members of the Executive Committee, four past presidents of the Association and the presidents of the five largest component county societies.

4. *Committee on Medical Technicians:*

Dr. Sampson, chairman of a special committee appointed earlier to review the functions and the roles of technicians in the fields of electronics and other specialties, presented a resolution which sought to define the place in the field of medicine of such technicians. On motion duly made and seconded, it was voted to approve this resolution and present it to the House of Delegates on behalf of the Council. (Resolution No. 1, 1953 Annual Session, House of Delegates.)

5. *Imperial County Hospital:*

Mr. Louis M. Welsh of legal counsel reported on meetings held in Imperial County to clarify the situation on admissibility of patients in the county hospital. He reported that Dr. Wheeler, Mr. Pettis and he had met with local physicians and believed the situation was now straightened out and the hospital operating along lines approved by the courts and the medical societies.

6. *Financial:*

(a) A report of bank balances as of May 16, 1953, was presented and ordered filed.

(b) Discussion was held on possible methods of handling the bookkeeping on the balance due the Association from New Mexico Physicians' Service. It was pointed out that the original loan of $18,000 had been reduced to $8,750 and that the assets of N.M.P.S. were inadequate to make further payments on this balance. On motion duly made and seconded, it was voted to delete this asset item, with its accompanying reserve item, from the books of the Association, with the agreement of the certified public accountant, but to keep intact the notes given by N.M.P.S. for funds advanced and to negotiate with N.M.P.S. for the acquisition of security for the balance due.

(c) Dr. Lum, chairman of the Auditing Committee, presented the proposed budget for the 1953-1954 fiscal year. The Council discussed this budget and on motion duly made and seconded, voted to delete a $6,000 item for retention of public relations counsel.

On motion duly made and seconded, it was voted to increase the honorarium to the editor of CALIFORNIA MEDICINE by $2,400 annually.

It was moved and seconded that the budget, as amended, be adopted by the Council for presentation to the House of Delegates, on the basis of dues of active members at $40 for the calendar year 1954.

A substitute motion, to set the annual dues at $36, without making further changes in the proposed budget, was regularly made, seconded and voted, the Chair casting the deciding vote. (Later revised to $40.)

(d) A request from the Riverside County Medical Association for possible assistance in meeting the costs of a disciplinary proceeding was discussed. On motion duly made and seconded, it was voted to advise the society that such expenses were properly a part of the county society's obligations, while the expenses of appeal proceedings are borne by the state and national organizations.

7. *California Physicians' Service:*

Dr. Donald Cass, president of California Physicians' Service, reported on internal reorganizations which have taken place in C.P.S. He also reported that a special committee of the Board of Trustees had been established to make a periodic review of the fee schedule. Contingency reserves are now accumulating at the rate of about $100,000 monthly and now total about $6,000,000. There are now 630,000 beneficiary members.

Mr. K. L. Hamman, Executive Vice-President of C.P.S., reviewed the financial situation of the organization.

Dr. Leslie B. Magoon commented on Dr. Cass' report and suggested that in view of a large percentage of C.P.S. beneficiaries now being over the income ceiling, the organization limit its issuance of further service contracts to those individuals under the income ceiling and provide those above the ceiling with an indemnity contract. He also suggested that any changes in the fee schedule be made only with the knowledge and consent of the entire profession.

8. *Medical Services Commission:*

Dr. Magoon, as chairman of the Medical Services Commission, reviewed the meetings and activities of that body to date. Five meetings have been held, each preceded by a meeting of the executive committee. The commission has to date considered its initial task one of self-education and has interviewed representatives of the A.M.A. Council on Medical Service, insurance brokers and others interested in the field of prepaid medical cost insurance. A subcommittee of the commission is working on a proposed set of principles which might be used as a yardstick in evaluating any prepayment plan. The

commission is also giving consideration to the status of voluntary health insurance in California.

Dr. Magoon recommended (1) that the Medical Services Commission be established in the Association through the By-Laws, (2) that the commission be authorized to appoint a subcommittee on fee schedules and that while this subcommittee is active, the present fee schedule committee of the Association remain inactive, (3) that the commission be authorized to expend $1,435 on a pamphlet on health insurance produced with the cooperation of the public relations department, and (4) that the terms of members of the commission which expire this year should be renewed for the coming three years.

Dr. Magoon expressed satisfaction with the assistance given by the Association office, especially by Mr. Robert Thomas, and stated that the commission has decided not to seek an executive secretary of its own at this time.

On motion duly made and seconded, it was voted to approve the $1,435 expenditure for health insurance pamphlets, this vote being recorded as more than three-fourths of the Council.

On motion duly made and seconded, it was voted to approve the appointment by the commission of a subcommittee on fee schedules.

9. *Advisory Planning Committee:*

(a) Mr. Hunton reported that the Advisory Planning Committee had considered the request of one county society for the application of newspaper advertising funds to local projects, rather than to the statewide advertisements prepared by the C.M.A. public relations department. It was the consensus of the committee that the advertisements prepared by the C.M.A. should be offered to the county societies for their use if they so desired, but that any project of a local nature should be a local responsibility. A certain degree of flexibility is possible in the C.M.A. advertisements, to meet local conditions. On motion duly made and seconded, it was voted to follow the policy enunciated by the Advisory Planning Committee.

Mr. Hunton also reported the consensus of the committee in regard to a statewide disability insurance program. The county society executive secretaries were particularly anxious that any statewide program of this type be first cleared with the county societies as a means of avoiding overlapping or direct competition.

10. *Group Disability Insurance:*

Dr. Kirchner, chairman of a special committee to investigate a group disability contract for Association members, reported on a policy offered by the Lumbermen's Mutual Insurance Co. through an insurance broker. Discussion was held on the terms of the proposed contract and on its possible acceptance by the component county societies. On motion duly made and seconded, it was voted to table the proposal for the time being.

At the recessed meeting of May 25, this proposal was lifted from the table and on motion duly made and seconded, it was voted to approve in principle the insurance contract offered and to submit it to the insurance committees of the component societies, for their action within 90 days. (Later amended to 30 days.)

11. *A.M.A. School Health Conference:*

On motion duly made and seconded, it was voted to appoint Secretary Daniels as the Association's representative at the A.M.A. School Health Conference to be held near Chicago in the fall.

12. *Public Relations:*

A communication from a member, taking issue with statements made publicly by an officer of a national medical organization was read and discussed. It was pointed out that the subject was due for a full discussion in the coming meeting of the House of Delegates of the American Medical Association. On motion duly made and seconded, it was voted to advise the member of the proposals to come before the A.M.A. and to advise the California delegates to the A.M.A. to give careful consideration to this matter.

13. *American Medical Education Foundation:*

Drs. Green and Bostick discussed the need of the American Medical Education Foundation for greater participation from California physicians. It was duly moved and seconded that the Council approve a resolution to be presented to the House of Delegates, calling for a per capita assessment of dues for this purpose, but on vote the motion was lost.

14. *Los Angeles County Physicians' Aid Association:*

Discussion was held on a proposal that the Association join with the Los Angeles County Physicians' Aid Association in caring for needy physicians and their families. No action was taken.

15. *Woman's Auxiliary:*

(a) On motion duly made and seconded, it was voted to appoint Drs. Dan O. Kilroy and Matthew N. Hosmer to the Advisory Committee to the Woman's Auxiliary, along with the President, President-Elect and Secretary.

(b) On motion duly made and seconded, it was voted to approve a new Constitution and By-Laws prepared by the Woman's Auxiliary, which could become effective only with Council approval.

Special Motion Regarding Adjournment:

On motion duly made and seconded, it was unanimously voted to adjourn the meeting out of respect to the late Howard Burrell, legal counsel to the California Hospital Association, and to prepare a suitable resolution to be forwarded to Mrs. Burrell.

Recess:

There being no further business to come before the meeting at that hour, the chairman announced a recess until 7:30 a.m., Sunday, May 24, 1953, in Conference Room 6 of the Biltmore Hotel, Los Angeles.

Reconvention—Sunday, May 24, 1953:

The meeting was reconvened at 7:30 a.m., Sunday, May 24, 1953, in Conference Room 6 of the Biltmore Hotel, Los Angeles.

A quorum present and acting.

16. *Cancer Commission:*

Dr. Daniels reported that the Cancer Commission was interested in purchasing a projection machine for x-ray plates. It was duly moved, seconded and voted to authorize the purchase of this machine at a cost of not more than $500, chargeable to the budget of the Cancer Commission.

17. *Blood Bank Commission:*

Dr. Morrison discussed the request of the Tri-Counties Blood Bank in Santa Barbara for a loan to permit the establishment of new quarters. He reported that since the original request had been made, the blood bank had sold its original property and no longer needed the funds it had requested. In view of this fact and in keeping with the initial policy of making such loans only for the establishment of new blood banks, it was duly moved, seconded and voted to follow the original policy of restricting these loan funds to new blood banks.

18. *Committee on Blue Shield-Blue Cross:*

Dr. Alesen reported on meetings held by the Joint Committee on Blue Shield-Blue Cross and presented a resolution for introduction in the House of Delegates. On motion duly made and seconded, it was voted to present this resolution to the House of Delegates on behalf of the Council. (Resolution No. 2, 1953, House of Delegates.)

19. *By-Law Amendment:*

Attention was called to an earlier Council resolution to present an amendment to the By-Laws to eliminate from the Standing Committees the Committee on Medical Defense, which has been obsolete for a number of years. On motion duly made and seconded, it was voted to present this By-Law amendment to the House of Delegates covering Chapter VII, Section 1(c) and Section 10.

20. *Appreciation to Dr. Donald Cass:*

It was duly moved, seconded and unanimously voted to present to the House of Delegates a resolution expressing commendation of Dr. Donald Cass for his long and devoted service as a trustee and president of California Physicians' Service, upon the occasion of his retirement from that post.

Recess:

At this point, the Chair announced a recess until 7:30 a.m., Monday, May 25, 1953, in Conference Room 6 of the Biltmore Hotel, Los Angeles.

Reconvention:

The meeting reconvened at 7:30 a.m., Monday, May 25, 1953, in Conference Room 6 of the Biltmore Hotel, Los Angeles.

A quorum present and acting.

21. *Committee on Problems of the Aging:*

Dr. Donald Campbell, chairman of a special committee on the problems of the aging, presented a progress report. The chairman thanked Dr. Campbell for his thorough report and the recommendations were taken under consideration.

22. *Committee on Industrial Accident Commission:*

Dr. Francis J. Cox, chairman of the Committee on Industrial Accident Commission, reported that Senate Bill 1066 was well on its way through the Legislature and that his committee would continue to work for an adequate schedule of industrial fees. The chairman thanked Dr. Cox for his progress report.

23. *Council Members on C.P.S. Board of Trustees:*

Dr. Ivan C. Heron reported on the Council representation on the Board of Trustees of California Physicians' Service and gave his impression that the actions of the board have been taken with wisdom and in the interests of all parties concerned.

24. *Physician Placement:*

Dr. John Ruddock, Southern California chairman of the Advisory Committee to Selective Service, reported on physicians returning to civilian life from military service and expressed the hope that the Association might extend to all areas of the state the placement service now operated principally in the northern counties. This matter was referred to Mr. Robert Thomas for execution.

25. *Morbidity Study:*

Discussion was held on the morbidity study recently completed in Santa Clara County and it was agreed to refer this matter to the Committee on Public Health and Public Agencies.

Recess:

At this point, 9:00 a.m., Monday, May 25, 1953, the meeting was recessed until 7:30 a.m., Tuesday, May 26, 1953.

Reconvention:

The meeting was reconvened at 7:30 a.m., Tuesday, May 26, 1953, in Conference Room 6 of the Biltmore Hotel, Los Angeles.

A quorum present and acting.

26. *Physician Placement:*

On motion duly made and seconded, it was voted to make the Association's physician placement system (item 24, above) statewide.

27. *Committee on Unlawful Practice of Medicine:*

Discussion was held on the immediate program of the Committee on Unlawful Practice. It was agreed that the functions of this committee should be to contact other groups to secure compliance with the medical practice laws, to investigate areas of unlawful practice, to maintain liaison with the Board of Medical Examiners and, failing agreement in any sector, to seek injunctions to prevent unlawful practice. It was also agreed that the medical schools of the state be asked to instruct their students in medical ethics and the responsibilities of physicians.

28. *Association Dues for 1954:*

It was reported that the Reference Committee on Finance of the House of Delegates proposed to reverse the Council's earlier decision and recommend that dues for active members for 1954 be placed at $40. On motion duly made and seconded, it was voted to support the recommendation of the reference committee.

29. *Recognition of County Secretaries:*

Councilor Morrison, chairman of a special committee to consider official recognition of county society secretaries, presented a scroll which could be presented to county society secretaries who had served five years or more. On motion duly made and seconded, it was voted to approve the presentation of such a scroll on the occasion of each five years of service of a county secretary.

30. *Ethical Status Re—Osteopaths:*

Dr. Alesen made a progress report on meetings with leaders of the osteopathic profession and it was duly moved, seconded and voted to instruct the Association's delegates to the A.M.A. to support a plan to clarify the ethical considerations concerning osteopaths.

Recess:

At this point, 10:10 a.m., the meeting was recessed until 7:30 a.m., Wednesday, May 27, 1953.

Reconvention:

The meeting was reconvened at 7:30 a.m., Wednesday, May 27, 1953, in Conference Room 6 of the Biltmore Hotel, Los Angeles. A quorum present and acting.

31. *Appointments to Standing Committees:*

Dr. Daniels reported on the nominations for membership on standing committees and on motion duly made and seconded, these appointments were approved.

32. *Group Disability Insurance:*

Dr. Kirchner moved an amendment to the Council's earlier vote (item 10, above) on a group disability insurance program, to provide for consideration of the proposed program by the county societies within 30, rather than 90, days. The motion was seconded and adopted.

33. *State Department of Public Health:*

Dr. Wilton L. Halverson, State Director of Public Health, reported on several legislative proposals. A bill to provide public health services in vacation areas of the state has been signed into law and his department will work with the C.M.A. Committee on Rural Health and the Supervisors' Association to implement this measure. A rabies control bill has reached the floor of the Senate (this measure was later defeated) and a milk pasteurization bill has been tabled.

Dr. Halverson reported that the morbidity study in Santa Clara County had expended about $100,000 to determine methods. The advisory committee on this study, including Drs. West and C. V. Thompson, has recommended that no further studies along this line be made until the results of the pilot study can be evaluated.

To date this year, Dr. Halverson reported, there have been 521 cases of poliomyelitis and the current rate of incidence is about the normal expectancy. About 25 per cent of the state's allocation of gamma globulin has been received or shipped to date and if all 18,000 doses are used on immediate contacts, it is expected that about 40 cases of polio may be prevented, out of an anticipated 3,000 cases.

The outlook for encephalitis indicates a low incidence.

34. *Blood Bank Commission:*

Dr. John R. Upton, chairman of the Blood Bank Commission, reported that only a handful of blood donors had offered blood for the gamma globulin program. He reviewed the blood banking situation in California and was thanked by the chairman for his continued good work.

35. *Annual Sessions:*

On motion duly made and seconded, it was voted to hold the 1954 Annual Session in Los Angeles.

On motion duly made and seconded, it was voted to hold the 1955 Annual Session in San Francisco.

36. *Interim Session:*

On motion duly made and seconded, it was voted to hold the 1953 Interim Session in San Francisco.

37. *Committee on Public Health and Public Agencies:*

(a) Dr. Francis E. West and Dr. C. V. Thompson reported on the Santa Clara County pilot study on morbidity, reaffirming the earlier report made by Dr. Halverson.

(b) On gamma globulin, Dr. West reported that all interested parties in San Diego County have agreed to a series of press releases to advise the public on the true situation. This series will extend over the next three months and Dr. West suggested similar procedures for other counties.

(c) Report was made on studies relative to the use of penicillin ointment in the eyes of the newborn. The State Department of Public Health has approved a new regulation which would permit the physician to use his own discretion in using this agent or silver nitrate as required for many years.

(d) Dr. West reported on a recent meeting at which members of the committee and of other organizations had approved the continuation of the use of the means test for cases of tuberculosis. The same meeting disapproved the requirement of a lien on future assets of tubercular patients in county institutions.

On motion duly made and seconded, it was voted to approve further studies of the results of the Santa Clara County morbidity survey.

On motion duly made and seconded, it was voted to approve the report of the committee as a whole.

38. *Public Policy and Legislation:*

Mr. Hassard reported that a legislative measure which would have approved a short-term medical school had failed to qualify before a committee in the Legislature and could not be reactivated at this session. He also reported on several other measures before the Legislature.

39. *Annual Session Exhibits:*

On motion duly made and seconded, it was voted to record the Council's approval of the organization and layout of the exhibits at the Annual Session.

On motion duly made and seconded, it was voted to express to the exhibitors at the Annual Session the Council's appreciation and thanks for their excellent cooperation.

40. *Retiring Councilors:*

On motion duly made and seconded, the Council voted unanimously to express its appreciation to President Alesen and Councilors Pollock and Montgomery, all retiring at this time.

Adjournment:

There being no further business to come before it, the meeting was adjourned at 9:05 a.m., out of respect to the late Howard Burrell.

SIDNEY J. SHIPMAN, M.D., *Chairman*
ALBERT C. DANIELS, M.D., *Secretary*

* * *

400th Meeting

The meeting was called to order by Chairman Shipman at 8:00 a.m., Thursday, May 28, 1953, in Conference Room 6 of the Biltmore Hotel, Los Angeles.

Roll Call:

Present were President Green, President-Elect Morrison, Speaker Charnock, Secretary Daniels, Councilors West, Wheeler, Loos, Sampson, Ray, Lum, Frees, Carey, Shipman, Varden, Kirchner, Heron, Pearman, Teall and Reynolds.

A quorum present and acting.

Present by invitation were Messrs. Hunton, Thomas, Gillette and Pettis of C.M.A. staff, Legal Counsel Hassard, county executive secretary Watson of Sacramento and Drs. Elmer E. Wadsworth and Dan O. Kilroy.

1. *Introduction of New Members:*

The chairman introduced Drs. T. Eric Reynolds, Ralph Teall and Robert O. Pearman, newly elected Councilors, and welcomed them.

2. *Organization of Council:*

On nomination duly made and seconded, Dr. Sidney J. Shipman was unanimously elected chairman of the Council.

On nomination duly made and seconded, Dr. Donald D. Lum was unanimously elected vice-chairman of the Council.

3. *Appointment of Auditing Committee:*

The Chairman, with the unanimous consent of the Council, appointed Dr. Lum chairman and Drs. Ivan C. Heron and T. Eric Reynolds members of the Auditing Committee.

Recess:

At this point the Council recessed to permit a meeting of the Trustees of the California Medical Association. Upon the completion of that meeting, the Council reconvened.

4. *Committee on Postgraduate Activities:*

Dr. Edward C. Rosenow, chairman of the Committee on Postgraduate Activities, reported that the committee has now standardized the honoraria allowed speakers.

He asked authority to set the registration fee at postgraduate institutes at $10, which, upon motion duly made and seconded, was approved.

Dr. Rosenow also reported that the committee was experimenting with tape recordings of scientific papers and asked authority to investigate the possibilities of that type of lecture material. On motion duly made and seconded, approval of this activity was voted.

5. *Student Nurse Recruitment:*

Mr. Robert Thomas reported that student nurse recruitment was now being handled through the joint efforts of the California League for Nursing, the California Hospital Association and the California Medical Association. On motion duly made and seconded, it was voted to appoint Mr. Thomas as the Association's representative on the committee handling this project.

On motion duly made and seconded, it was voted to send letters of thanks to the various nurse training schools which had cooperated in the Annual Session by supplying student nurses for various duties.

6. *Southern California Office:*

Dr. Lum suggested that in view of expanded activities in the Southern California area, the Association's Los Angeles office might be expanded and additional legal services provided. It was agreed to ask the executive secretary to seek suitable office quarters in Los Angeles and to provide an estimate of the cost of establishing and operating a more adequate office, report to be made at a later meeting.

7. *Legal Retainer:*

On motion duly made and seconded, it was voted to add $3,000 annually to the retainer fee for legal counsel, effective June 1, 1953.

8. *Employees' Retirement Program*

Dr. Charnock submitted a report in connection with the employees' retirement program and employees' severance pay. With respect to severance pay, Dr. Charnock was authorized to consult with those employees not participating in the retirement program and to submit a definite plan to the Council. With respect to the retirement program, it was voted to transfer legal ownership of the present insurance annuity policies to the "Trust Fund for California Medical Association Employees" this day established by the corporation trustees of the California Medical Association. It was voted to transfer such initial funds to said "Trust Fund for California Medical Association Employees" as may be necessary in the judgment of the Auditing Committee.

Adjournment:

There being no further business to come before it, the meeting was adjourned at 11:30 a.m., the next meeting to be at the call of the chairman.

SIDNEY J. SHIPMAN, M.D., *Chairman*
ALBERT C. DANIELS, M.D., *Secretary*

In Memoriam

BRIGGS, LEROY H. Died in San Francisco, June 29, 1953, aged 70. Graduate of the University of California Medical School, Berkeley-San Francisco, 1908. Licensed in California in 1908. Doctor Briggs was a retired member of the San Francisco Medical Society, the California Medical Association, and an associate member of the American Medical Association.

✤

BROWNELL, EMILY M. BAER. Died in San Diego, June 11, 1953, aged 43. Graduate of the University of Illinois College of Medicine, Chicago, 1936. Licensed in California in 1943. Doctor Brownell was a member of the San Diego County Medical Society, the California Medical Association, and the American Medical Association.

✤

MILLER, JOHN J., JR. Died in San Francisco, June 13, 1953, aged 49, of carcinoma. Graduate of Stanford University School of Medicine, Stanford University-San Francisco, 1929. Licensed in California in 1931. Doctor Miller was a member of the San Francisco Medical Society, the California Medical Association, and the American Medical Association.

NELSON, ELFORD J. Died in Pomona, June 10, 1953, aged 57, of coronary artery disease. Graduate of the University of Toronto Faculty of Medicine, Ontario, Canada, 1920. Licensed in California in 1948. Doctor Nelson was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✤

STEELE, EDSON H. Died in Los Angeles, June 23, 1953, aged 58, of subarachnoid hemorrhage. Graduate of Albany Medical College, New York, 1919. Licensed in California in 1923. Doctor Steele was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✤

WHALEN, JOHN F. Died in Altadena, July 4, 1953, aged 53, of coronary artery disease. Graduate of Jefferson Medical College of Philadelphia, Pennsylvania, 1927. Licensed in California in 1928. Doctor Whalen was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

CALIFORNIA MEDICAL ASSOCIATION

Annual Meeting

LOS ANGELES
May 9-13, 1954

Papers for Presentation

If you have a paper that you would like to have considered for presentation, **it should be submitted to the appropriate section secretary** (see list on this page) not later than November 15, 1953.

Scientific Exhibits

The space available for scientific exhibits is limited. If you would like to apply for space, please write immediately to the office of the California Medical Association, 450 Sutter Street, San Francisco 8, for application forms. To be given consideration by the Committee on Scientific Work, the forms, completely filled out, must be in the office of the California Medical Association not later than December 1, 1953. (No exhibit shown in 1953, and no individual who had an exhibit at the 1953 session, will be eligible until 1955.)

SCIENTIFIC PAPERS . . .

. . . SCIENTIFIC EXHIBITS

PLANNING MAKES PERFECT

AN EARLY START HELPS

SECRETARIES OF SCIENTIFIC SECTIONS

Allergy . . . . . *Lazarre J. Courtright*
490 Post Street, San Francisco 2

Anesthesiology . . . . . *Marshall L. Skaggs*
18 Hillcrest Road, Mill Valley

Dermatology and Syphilology . . *Walter F. Schwartz*
696 East Colorado Street, Pasadena 1

Eye, Ear, Nose and Throat—

Eye . . . . . *Alfred R. Robbins (Chairman)*
1930 Wilshire Boulevard, Los Angeles 57

ENT . . . . . *Francis A. Sooy*
490 Post Street, San Francisco 2

General Medicine . . . . . *Edgar Wayburn*
490 Post Street, San Francisco 2

General Practice . . . . . *Joseph W. Telford*
3255 Fourth Avenue, San Diego 3

General Surgery . . . . . *William Brock*
2633 Pacific Avenue, Stockton 4

Industrial Medicine and Surgery . . . . *Verne G. Ghormley (Asst. Secty.)*
2014 Tulare Street, Fresno

Obstetrics and Gynecology . . . *Charles T. Hayden*
411 Thirtieth Street, Oakland 9

Pathology and Bacteriology . . . . . *Paul Michael*
450 Thirtieth Street, Oakland 9

Pediatrics . . . . . *Gordon F. Williams*
1111 University Drive, Menlo Park

Psychiatry and Neurology . . . *George N. Thompson*
2010 Wilshire Boulevard, Los Angeles 57

Public Health . . . . . *L. S. Goerke*
116 Temple Street, Los Angeles 12

Radiology . . . . . *H. R. Morris*
1027 "D" Street, San Bernardino

Urology . . . . . *Thomas I. Buckley*
431 Thirtieth Street, Oakland 9

NEWS & NOTES

NATIONAL • STATE • COUNTY

LOS ANGELES

The National Gastroenterological Association will hold its 18th Annual Convention and Scientific Sessions at the Biltmore Hotel in Los Angeles, October 12-14, 1953. Following the convention, on October 15, 16 and 17, the Association's Fifth Annual Course in Postgraduate Gastroenterology will be given at the Biltmore Hotel and the College of Medical Evangelists in Los Angeles. The course will be under the personal direction of Drs. Owen H. Wangensteen of Minneapolis and I. Snapper of Chicago, who will be assisted by a faculty from the medical schools in and around Los Angeles.

Further information concerning the program and details of the postgraduate course may be obtained by writing to the Executive Officer, National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.

* * *

The staff of **Saint John's Hospital,** Santa Monica, will present its Fifth Annual Postgraduate Assembly, September 14, 15 and 16. Guest speakers are Forrest H. Adams, M.D., associate professor of pediatrics, U.C.L.A. School of Medicine; William S. Adams, M.D., associate professor of medicine, U.C.L.A. School of Medicine; William Boyd, M.D., professor of pathology, University of British Columbia, Vancouver, Canada; William A. Cooper, M.D., associate professor of clinical surgery, Cornell University, New York; L. Henry Garland, M.D., clinical professor of radiology, Stanford University School of Medicine, San Francisco; Willard E. Goodwin, M.D., professor of urological surgery, U.C.L.A. School of Medicine; Frank J. Heck, M.D., professor of medicine, Mayo Clinic, Rochester, Minnesota; Mr. Murray Kahane, psychologist, Marion-Davies Clinic; Louis Lichtenstein, M.D., pathologist, Wadsworth Veterans Hospital, Los Angeles; Newell W. Philpott, M.D., professor of obstetrics and gynecology, McGill University, Montreal, Canada; and Joseph Teicher, M.D., psychiatrist, Marion-Davies Clinic, and director of the Los Angeles Child Guidance Clinic.

The assembly is approved by the Council on Medical Education and Hospitals of the American Medical Association. Registration is open to all members of the medical profession. The fee is $10. Further information may be had from John C. Egan, M.D., Saint John's Hospital, Santa Monica.

* * *

Dr. Gordon Goodhart was appointed dean of Southern California School of Medicine, effective July 1. He had been associate dean for the past year and he succeeds Dr. Burrell O. Raulston, dean for ten years and on the faculty since 1929, who will become dean emeritus.

SAN FRANCISCO

Establishment of an **orthopedic clinic** at Saint Francis Memorial Hospital, San Francisco, was announced recently by Dr. C. P. Thompson, president of the board of trustees of the hospital. Aims of the clinic are to aid patients who are in difficult financial circumstances, assist the teaching program for resident physicians and promote research. The hospital's memorial endowment fund will support the clinic insofar as possible. However, there will be small charges for each visit and for x-rays, drugs and hospitalization.

* * *

Five all-day **seminars** are to be held at **Children's Hospital,** San Francisco in the season of 1953 and 1954:

October 31, 1953, Nevi, Tumors and Malignancies in Childhood.

December 5, 1953, Surgery and Anesthesia in Childhood, with a discussion on the effects of hospitalization on the young child for surgical procedures.

January 23, 1954, The Problems of Prematurity and the Newborn Infant.

March 20, 1954, Acute and Chronic Infections and the Choice of Antibiotics in Treatment.

April 24, 1954, Childhood Ecology, with a discussion of physical, mental and emotional growth and development of the young child; the effects of deprivation of maternal care, and the impact of environment on the child.

Further information may be obtained from H. E. Thelander, M.D., Children's Hospital, 3700 California Street, San Francisco.

GENERAL

The American Urological Association has announced the opening of competition for its annual award of $1000 (first prize of $500, second prize $300 and third prize $200) for essays on the result of some clinical or laboratory research in urology. Competition is limited to urologists who have been in such specific practice for not more than ten years, and to men in training to become urologists. Full particulars may be obtained from the executive secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before February 1, 1954.

All insurance companies writing **workmen's compensation insurance** in California have now adopted standard report forms. These forms, to be used henceforth in all industrial accident cases, will simplify the paper work in physicians' offices in reporting and billing. They will be supplied by the insurance companies on request. Arrangements have also been made for physicians to purchase their own supplies on the four forms used; if desired, the physician's name and address can be imprinted on the forms for positive identification. It is believed that many physicians handling a small volume of industrial work will want to keep on hand the small pads of 100 each of Forms 5020-A and 5020-B, the supplemental report and the final report and bill. A packet of 100 each of these forms will be supplied by the printer for $1.95 postage paid, or a packet of 500 each for $7.95. Quantities of 1000 or more may be bought at lower unit prices.

Inquiries about these standard forms should be sent direct to the Crenshaw Printers and Stationers, 2543 Crenshaw Blvd., Los Angeles 16. Telephone REpublic 3-1652. The forms are **not** handled by the C.M.A.

The American Dermatological Association has announced **a contest for a series of prizes** for the best essays submitted on original work, not previously published, relative to some fundamental aspect of dermatology or syphilology. Cash prizes will be awarded as follows: $500, $300 and $200 for first, second and third place, respectively.

Manuscripts must be submitted not later than December 1, 1953. Details of the contest may be obtained from Dr. J. Lamar Callaway, Secretary, American Dermatological Association, Duke Hospital, Durham, North Carolina.

POSTGRADUATE EDUCATION NOTICES

MEDICAL EXTENSION UNIVERSITY OF CALIFORNIA

Postgraduate Courses for 1953

Obstetrical and Gynecological Conference, September 2, 3, 4. Place and fee to be announced.

Ophthalmology (for specialists), September 7 through 12. Fee $75.00. Medical Center.

Medicine for General Practitioners, September through November. East Oakland Hospital. Fee $50.00.

Evening Lectures in Medicine, September through November. Fee $50.00. Mills Memorial Hospital, San Mateo (probably).

Occupational Health, October 14, 21, 28 and November 4. Fee to be announced. Medical Center.

Contact: All inquiries to be addressed to Stacy R. Mettier, M.D., Professor of Medicine, Head of Postgraduate Instruction, Medical Extension, University of California Medical Center, San Francisco 22.

UNIVERSITY OF CALIFORNIA AT LOS ANGELES

1. What's New in Therapeutics—Wednesday, August 12.
2. Office Gynecology—Wednesday, August 19.
3. Peripheral Vascular Diseases—Wednesday, August 26.

All of these one-day symposia will be given at the U. S. Naval Hospital in San Diego, and they are being given in cooperation with the San Diego County Medical Society.

Contact: Dr. Thomas Sternberg, Office of Medical Extension, University Extension, University of California, Los Angeles 24, California.

UNIVERSITY OF SOUTHERN CALIFORNIA SCHOOL OF MEDICINE

Cardiology and Vascular Disease—No. 832

Date: September 14, 1953—full time, one year.

Fee: $1,000.00.

History, physiology, pathology, diagnosis, treatment of cardiac and peripheral disease. Emphasis placed on bedside teaching, electrocardiography, fluoroscopy, and associated diagnosis aids. Designed to meet the requirements for certification by the American Board of Cardiology. Six hours of didactic lectures per week; 35 hours of laboratory work. 32 units credit for master's degree. Course Director: George C. Griffith, M.D.

Gastroenterology—No. 844

Date: September 21, 1953—Full time, one year.

Fee: $1,000.00.

Course is designed to give a limited number of qualified physicians advanced training in this field. The didactic courses will include intensive study of the physiology, pathology, as well as the clinical aspects of the diseases of the digestive tract. Clinical teaching will be done in the outpatient department of the Los Angeles County Hospital. 32 units credit for master's degree. Course Director: George K. Wharton, M.D.

Intensive Review of Internal Medicine—No. 855

Date: September 21, 1953. Applications accepted until August 1, 1953.

Fee: $50.00.

A two-week course offered for students preparing to take the examination for the American Board of Internal Medicine. Course consists of 40 hours of didactic lectures, 8:30 a.m. to 12:30 p.m., Monday through Friday. It will cover the fields of Endocrinology, Cardiology, Gastroenterology, Hematology, Arthritis, Neurology, and Isotopes. Course Director: Donald Petit, M.D.

Diagnostic and Therapeutic Radiology—No. 858

Date: Course begins by arrangement.

Fee: 3 mos.—$250.00 6 mos.—$ 500.00
9 mos.—$750.00 12 mos.—$1,000.00

This course is designed for a limited number of qualified physicians who wish to prepare for the American Board of Radiology, and who wish specialized training in a particular field of medicine such as orthopedics, cardiology, etc. Course will be conducted in the Department of Radiology at the Los Angeles County Hospital. Course Directors: Ray A. Carter, M.D., George Jacobson, M.D.

Anesthesia

Date: Course begins by arrangement.

Fee: $300.00 (full time, three months).

Basic principles and techniques involved in administering the various anesthetic agents, including oxygen therapy and operating room care of patients. Open to a limited number of qualified physicians and dentists. Emphasis placed on practical administration of anesthetic agents. Presented at the Los Angeles County Hospital. Course Director: J. S. Denson, M.D.

Contact: Gordon E. Goodhart, M.D., University of Southern California School of Medicine, Division of Medical Extension Education, 1200 North State Street, Box 158, Los Angeles 33, California.

COLLEGE OF MEDICAL EVANGELISTS

Full-Time Basic Science Course in Surgery and Surgical Specialties—Date: October 5, 1953 through June 11, 1954. Fee to be announced.

Contact: H. M. Walton, M.D., Chairman, Postgraduate Division, 312 North Boyle Avenue, Los Angeles 33.

RESEARCH STUDY CLUB OF LOS ANGELES

23rd Annual Clinical Convention of Ophthalmology and Otolaryngology.

Date: January 18 through January 29, 1954. Each applicant must be a member in good standing of the American Medical Association in order to become eligible for attendance.

Fee: $100.00.

Contact: Pierre Violé, M.D., Treasurer, 1930 Wilshire Boulevard, Los Angeles 5, Calif.

THE PHYSICIAN'S *Bookshelf*

A MANUAL OF CLINICAL ALLERGY. John M. Sheldon, M.D., Professor of Internal Medicine and Assistant to the Chairman of the Department of Postgraduate Medicine; Robert G. Lovell, M.D., Instructor in Internal Medicine, and Kenneth P. Mathews, M.D., Assistant Professor of Internal Medicine, all at the University of Michigan Medical School. W. B. Saunders Company, Philadelphia, 1953. 413 pages with 27 figures, $8.50.

Physicians interested in studying and treating allergic disease as a part of their practice and laboratory technicians will find this manual of great value in establishing diagnostic methods and selecting their equipment for office and laboratory and as a practical supplement to standard reference books on allergy. The sections on skin testing and other laboratory procedures, patch testing, identification of air-borne allergens, the preparation of antigens and vaccines, and office planning are clearly presented. General practitioners and allergists alike will find the chapter on patch testing of particular interest.

Drug therapy in allergic disease is well presented. The list of proprietary preparations with a breakdown of their contents is to be commended. In general, however, the methods and problems of therapy are inadequately covered. The outline of desensitization procedures is too briefly presented. The value of high dilutions of antigens in highly sensitive individuals is not discussed. Problems in the diagnosis and treatment of food allergy deserve more discussion. Illustrations and tables are clearly presented, especially those dealing with the identification of pollen-bearing plants and molds. The index is complete and the text is well written and easy to read.

* * *

CLINICAL ALLERGY. French K. Hansel, M.D., M.S., Director, Hansel Foundation for Education and Research in Allergy; Chief of Allergy Service, DePaul Hospital, St. Louis. The C. V. Mosby Company, St. Louis, 1953. 1,005 pages, 86 illustrations and three color plates, $17.50.

As stated in the preface, "Clinical Allergy" is a complete textbook on the general subject of allergy. The author has performed a monumental work in the gathering, classifying and presenting of his subject. A number of good textbooks on allergy, by other outstanding men, are available, but here, for the first time, is a complete codification and presentation of all the data presently available.

Because of the highly specialized terminology employed in the field of allergy, the author has included a complete glossary of the common terms, which is the first time this has been done in such a book. This will prove a distinct advantage to the general practitioner or beginner in allergy. It will clarify for physicians who are not specialists in allergy, the articles which appear constantly in the medical literature as well as this book and other similar ones.

The volume includes no less than 53 chapters and runs to slightly more than one thousand pages. The entire field of allergy is thoroughly covered, beginning with the terminology and history of allergy and continuing through all of its many phases. There are chapters devoted to the basic concepts of anaphylaxis and allergy; introduction to clinical allergy; allergy to biologic products; entomogenous allergy; allergy to drugs; foods as allergens, allergy to fungi; allergy to inhalants; history taking and diagnosis; supplies and preparation of dilutions; methods of diagnostic testing in allergy; allergy in otolaryngology; the nasal and sinus manifestations of allergy; the cytology of the secretions in allergy; hay fever; allergy in otology; allergy in ophthalmology; bronchial asthma (two chapters are devoted to this subject and a third discusses the sinuses and asthma); the primary management of the allergic patient; respiratory allergy; the antihistamines; ACTH and cortisone; treatment of allergic manifestations by immunologic methods; gastrointestinal allergy; food allergy; allergic dermatitis; cerebral allergy; the relation of allergy to the cardiovascular system. These chapter headings merely indicate the scope of the volume as there are many more chapters not mentioned here.

Five full chapters are used to adequately cover the very important subject of allergy in children. The chapters on childhood allergy include, in the following order: causes and prevention; respiratory manifestations; paranasal sinuses; gastrointestinal and other manifestations; dermatoses. These chapters should be of great assistance to pediatricians as well as general practitioners who see many cases of allergy in children.

The index is complete and accurate and should enable the busy physician with a minimum of time to find the answers to his questions concerning allergy.

The earlier book by French K. Hansel, M.D., "Allergy of the Nose and Paranasal Sinuses," which was published in 1936 was excellent in its field. However, as the title indicates, its field was limited. With the publication of "Clinical Allergy," however, he has widened the scope of his subject to cover the entire field of allergy. Dr. Hansel's stated purpose in this book was to present a complete text on the subject of allergy and he has certainly succeeded in doing so. It is recommended wholeheartedly and without reservations to all medical students and to all physicians interested in this field of medicine.

* * *

THE PHARYNX—Basic Aspects and Clinical Problems. Edited by Abraham R. Hollender, M.D., F.A.C.S., Professor of Otolaryngology, Emeritus, University of Illinois College of Medicine. The Year Book Publishers, Inc., 200 East Illinois, Chicago, 1953. 560 pages, $15.00.

This book is worthwhile and practical. The anatomy, physiology and significance of pharyngeal disorders and their relations to systemic disease are stressed. The subject matter presents contributions of several authors. The diagnostic methods and therapeutic recommendations are modern and current.

The format of the book is somewhat unusual. Each chapter starts with an editorial introduction and is concluded with an editorial comment.

DIRECT ANALYSIS—Selected Papers. John N. Rosen, M.D. Grune and Stratton, New York, 1953. 184 pages, $3.75.

In recent years a good deal of attention has been given to a special type of psychotherapy which has been worked out by Dr. John N. Rosen. Dr. Rosen gives the term "Direct Analysis" to his method of therapy and theory of schizophrenia. This technique of treatment has been utilized almost entirely in the treatment of schizophrenics and the author reports quite optimistically on the treatment of extremely uncooperative schizophrenics, many of whom were considered hopelessly chronic deteriorated cases.

The book consists of nine papers, only one of which was written especially for this book, the other eight papers being revised versions of papers published between 1946 and 1952. As published, the volume is an excellent presentation of the author's views and the techniques of treatment which he uses. Paper 1, entitled "Direct Analysis: General Principles," is essentially a summary of the author's views. In general these views follow the theories of Freud, but the technique of treatment is in many ways the exact opposite of the orthodox treatment of Freud, with the patient lying on a couch and with emphasis on the passive attitude on the part of the therapist.

The author has a number of interesting formulations which are quite clearly presented and which are at variance with most of the theories and techniques in general use. The reviewer would not agree with a number of these ideas presented by the author, but would recommend that anyone interested in the treatment of schizophrenia should familiarize himself with this material, which certainly merits careful study by any student of psychiatry. At least the author is entitled to a good deal of credit in breaking away from orthodox doctrines and attempting to work out his own formulation. His reasons for all this are given, his results are also stated and the reader can draw his own conclusions from this very clear and interesting presentation.

* * *

GASTRIC CANCER. Alfred H. Iason, M.D., Attending Surgeon, Adelphi Hospital; Director of Surgery, Brooklyn Hospital for the Aged; Instructor in Anatomy, New York Medical College; with illustrations by Alfred Feinberg, Instructor of Medical Illustration, Department of Pathology, College of Physicians and Surgeons, Columbia University. Grune and Stratton, New York, 1953. 316 pages, $7.50.

According to the author the book was written in order to summarize succinctly for the undergraduate student, the practicing physician and the surgeon, the cumulative literature concerning gastric cancer, and to crystallize the author's experience in that field. In a sense no doubt his objectives are reached and the book contains a great amount of useful information. In an apparent effort to include everything, however, there is a lack of emphasis on the important points which limits its value for students and physicians. The chapters are arranged in an orthodox manner, beginning with anatomy and histology, and continuing with incidence, etiology, pathology, symptomatology, diagnosis and finally surgery. A number of different surgical procedures are described, commencing with total gastrectomy, then different forms of subtotal resections and finally the varied palliative operations. No mention is made of the substitution of the cecum, colon or jejunum after total gastrectomy. The book consists largely of a collection of facts, opinions, and methods, and is of value to this extent. The author does not make known his own beliefs and preferences based on his own experiences and hence the book is lacking in that personal touch which adds so much to the interest and value of any work.

PSYCHOANALYSIS, MAN, AND SOCIETY. Paul Schilder, M.D., Ph.D., Late Research Professor of Psychiatry, New York University College of Medicine and Late Clinical Director of Bellevue Hospital Psychiatric Division. Arranged by Lauretta Bender, M.A., M.D., Professor of Clinical Psychiatry, New York University College of Medicine, Senior Psychiatrist, Bellevue Hospital, New York City. W. W. Norton & Company, Inc., 1951. 382 pages. $4.00.

This is a book of twenty chapters, nineteen of which were originally published as separate papers. Included in this book are discussions of alcoholism, criminality and the adjustment of man generally to society. Of particular interest to many will be Chapter 18, Psychoanalysis of Economics. Although it was published in the *Psychoanalytic Review* on October 1940, much of it is of great interest in view of the present tensions between the United States and Russia.

A comparison made about the views of Marx and Freud is of special interest. Schilder points out that both Marx and Freud were Jews. "Marx and Freud both found out that individuals live up to demands of which they are not conscious. However, Marx's ideologies comprise the economic and social forces as well as sexual behavior. The accent is on the former . . . Marx put the emphasis on the economic forces, self-preservation and reproduction in the widest sense, Freud on the libidinous (sexual) forces."

In discussing all the material in this chapter, Schilder makes use of conventional orthodox psychoanalytic interpretations. However, he does not hesitate to criticize Freud and does give Marx credit for emphasizing the importance of economic motives and the idea that these often affect individuals at an unconscious level. He feels that Freud has not understood all of this adequately and that his attempts to explain the desire for economic survival are unclear and inadequate. The following is worth quoting on this point: "The basic contention of Marxism is that economic drives and needs have to be fulfilled if the individual wants to continue living . . . One must admit that psychoanalysis has neglected this viewpoint to a great extent. . . . In psychoanalysis the necessity for food and for the satisfaction of hunger appears as oral libido. When one looks over large parts of the psychoanalytic literature one would not conceive the idea that one eats because one is hungry and wants food to sustain one's life, but would rather suppose that eating is a sly way of satisfying oral libido. . . . The overextension of the libido theory into the oral sphere is the beginning of the downfall of the psychoanalytic theory of instincts. It finally leads indeed to a pansexualism since, according to Freud, the death instincts are not immediately experienced."

This whole book is full of many interesting and stimulating observations and is recommended for reading not only by psychiatrists but by all those interested in problems of human behavior and man's relation to society.

* * *

DISORDERS OF THE CIRCULATORY SYSTEM. Edited by Robert L. Craig, M.D. A Symposium—Presented at the Twenty-fourth Graduate Fortnight of the New York Academy of Medicine, October 8 to 19, 1951. The Macmillan Company, New York, 1952. 304 pages, $5.50.

This group of good monographs on disorders of the circulatory system was presented before the New York Academy of Medicine in October 1951. It gives the reader a comprehensive understanding of present-day clinical practice and laboratory investigation—one which would require much more extensive study were it not compressed so well.

It is highly recommended for physicians and students with a particular interest in this field.